U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 30 September 2004

In the Matter of
FRANK GONZALES, JR.
Claimant

v.

MARINE CORPS MWR/
CONTRACT CLAIMS SERVICES, INC.
Employer/Insurer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Case Nos.: 2003 LHC 691
2003 LHC 692

OWCP Nos.: 15-46431
15-45257

Appearances: Mr. Steven M. Birnbaum, Attorney
For the Claimant

Ms. Kitty K. Kamaka, Attorney
For the Employer/Insurer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER –
Award of Permanent Partial Disability Compensation
Award of Additional Compensation under Section 14 (e)
Denial of Change of Physician
Award of Temporary Total Disability Compensation
Award of Medical Benefits
Denial of Section 8 (f) Relief

This case involves claims filed by Mr. Frank Gonzales, Jr., for disability compensation and medical benefits under the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. §§ 901 to 950, as amended ("Act"), as extended by the Non-Appropriated Fund Instrumentalities Act, 5 U.S.C. §§ 8171 to 8173, for injuries that he suffered while an employee of the Marine Corps Morale Welfare and Recreation ("Marine Corps MWR").

On November 7, 2002, through counsel, Mr. Gonzales filed a pre-hearing statement seeking disability compensation and medical benefits for knee injuries and cumulative injuries to his spine and upper and lower extremities. On December 18, 2002, the District Director

forwarded the pre-hearing statement to the Office of Administrative Law Judges. Pursuant to a Notice of Hearing, dated January 29, 2003 (ALJ I),[1] I conducted a formal hearing on May 14 and 15, 2003 in Honolulu, Hawaii, attended by Mr. Gonzales, Mr. Birnbaum, and Ms. Kamaka. My decision in this case is based on the hearing testimony and all the documents admitted into evidence: CX 1 to CX 16 and EX 1 to EX 54.

ISSUES

1. Left knee injury disability compensation and medical benefits

   A. Nature of disability

   B. Disability compensation

   C. Change of physician

2. Cumulative injuries/aggravation of pre-existing condition disability compensation and medical benefits

   A. Timely notice

   B. Injury

   C. Nature and extent of disability

   D. Medical benefits

3. Section 8 (f) relief

Parties' Positions

Claimant[2]

Mr. Gonzales worked as a labor and machine operator for Marine Corps MWR for over 15 years. In the 1960's, he suffered a back injury that led to a fusion operation. Although his back remained symptomatic, it did not disable him.

In June 2001, he suffered a work-related injury to his left knee. After surgery and physical therapy, Mr. Gonzales returned to work with restrictions. For a few months, he did not experience any problems. However, after being assigned to different equipment, his leg symptoms and limp increased. His symptomatic back also started to bother him. He stopped

[1]The following notations appear in this decision to identify exhibits: CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

[2]TR, pages 6 to 14, 20 to 21, 25 to 27, and closing brief, dated September 30, 2003.

work in July 2002 and eventually retired. Mr. Gonzales believes his retirement was medically justified.

For the initial left knee injury, Mr. Gonzales claims the nature of his associated disability is temporary. According to the two physicians who testified in the proceedings, Mr. Gonzales has not reached maximum medical improvement. Because the first knee surgery did not resolve his problem, Mr. Gonzales would benefit from another orthopedic evaluation of his left knee. Even if the nature of the left knee disability is determined to be permanent, no final disability rating has been presented. Additionally, Mr. Gonzales seeks appropriate monetary penalties for any overdue disability compensation payments.

In terms of medical treatment for his left knee, Mr. Gonzales seeks a change in his choice of physician. His first physician produced a poor result.

Due to wear and tear from his employment with Marine Corps MWR and aggravation from his left knee injury, Mr. Gonzales has also suffered cumulative injuries to his spine, both knees and upper extremities. His credible complaints of pain have established the existence of his injuries. Since the physical bouncing and activities associated with his work could have caused these injuries, Mr. Gonzales has also invoked the Section 20 (a) causation presumption. The Employer has failed to rebut that presumption. Consequently, Mr. Gonzales is entitled to disability compensation from the time he left work on July 25, 2002. In terms of nature and extent of disability, Dr. Hager believes Mr. Gonzales may benefit from additional medical treatment in the form of epidural injections. Additionally, Mr. Gonzales is unable to work due to these injuries. As a result, his disability is temporary total. Finally, having suffered a compensable injury, Mr. Gonzales is also entitled to medical care for the cumulative injuries.

Employer[3]

After Mr. Gonzales returned to work following his left knee surgery, the Employer provided jobs suitable for the physical restrictions imposed by the treating physician. When other physical problems came to light, the Employer offered Mr. Gonzales other positions, but he turned down the offers. Mr. Gonzales suddenly retired in November 2002.

According to the treating physician, Mr. Gonzales reached maximum medical improvement for his left knee in September 2001. Absent a referral to sports medicine, Dr. Ma rated his permanent disability as 20 % loss of use of the left lower extremity. Dr. Ma noted that while an additional referral might possibly help Mr. Gonzales, it probably would be ineffective.

Mr. Gonzales claims his cumulative injuries arose in April 2002 but he did not provide timely notice of those injuries to the Employer. Several months elapsed before Dr. Hager presented his diagnosis of cumulative injuries. The absence of the requisite timely notice has prejudiced the Employer by precluding prompt investigation of the circumstances that gave rise to the claimed injuries.

[3]TR, pages 15 to 18, 20, and closing brief, dated September 24, 2003.

Additionally, Mr. Gonzales has not sufficiently established the presence of any injuries to support a causation finding for cumulative injuries. No objective evidence supports a finding of such injuries. Notably, when Dr. Ma examined Mr. Gonzales in June 2002, he did not present any of the claimed injuries. According to Dr. Ma, Mr. Gonzales has suffered only a minor aggravation of a pre-existing condition and has reached maximum medical improvement. Due to an inadequate documentary basis, Dr. Hager's diagnosis does not support a finding of work-related cumulative injuries.

Mr. Gonzales is a voluntary retiree who does not want to work and was aware of his physical condition prior to retirement. Consequently, the post-retirement provisions of the Act are not applicable. Prior to his retirement, the Employer offered suitable alternative employment opportunities with Marine Corps MWR in August 2002 at $6 an hour. The treating physician approved two of the offered jobs, but Mr. Gonzales rejected the offers.

Summary of Evidence

While I have read and considered all the evidence presented, I will only summarize the information potentially relevant in addressing the issues.

Mr. Frank Gonzales, Jr.
(TR, pages 29 to 131, 260, and 261)

[Direct examination] Mr. Gonzales, who is 63 years old, started working for the Marine Corps MWR in August 1987. Prior to that employment, he retrained with Goodwill Industries for about two years. In his younger years, Mr. Gonzales worked construction. Later, he drove a school bus. Then, he worked for a tire dealer and hurt his back during that job. One day, as he was getting off a truck, he slipped on the metal bed due to oil on his shoes. He went up in the air and hit the rear of the truck with his back, breaking "the back part of my back." He suffered his back injury in the 1960's and underwent surgery. About a year after his back surgery, Mr. Gonzales returned to work at light duty. Eventually, he was released to full duty, which involved transporting passengers and light truck tires for the military bases. The work was not "very heavy. Just tires." If the load was heavy, he would use a lift. In the mid-1970s, he was laid off.

Because of his back injury, Mr. Gonzales had a difficult time finding another job. So, he got into a program that helped with re-employment. At the time, his back wasn't hurting and he saw a doctor only "once in a while."

When he was hired by the Marine Corps MWR through the re-training program, they knew about his back problem. Mr. Gonzales was employed as a laborer, but it didn't involve any heavy lifting. He lifted "little rubbish cans" weighing about 20 pounds and performed other maintenance work at the golf course, including punching holes in the greens.

Eventually, after about five years, Mr. Gonzales was promoted to the position of a machine operator. Later, he was promoted to "bigger machines." Then, he got a position as a supervisor of laborers. However, because Marine Corps MWR did not have enough laborers, they moved him back to the machine operator position.

As a machine operator in June 2001, Mr. Gonzales started his work day at 5:00 a.m. His job did not involve any bending and was not difficult. At that time, he did not have any problems with his left knee or low back. His back pains would come and go, "is a natural thing, you know."

One morning in June 2001, on a Friday, Mr. Gonzales was operating a "tee" mower cutting the golf course greens. He was wearing rubber boots because the grass was wet in the morning from either rain or automatic sprinklers. While cutting around the putting area, he "stepped on the machine and my left leg went to the right. And I heard a clucking sound and I had a funny pain, a numb piercing pain that aggravated me." He paused a few minutes because he really didn't know what had happened. He went back on the machine for a while and then reported what happened to his supervisor. Mr. Gonzales finished his work that day but told the superintendent that his knee was hurting. By the end of the day, his left knee was swollen and he suffered "aggravating pain." They gave him some paperwork to fill out over the weekend. However, the pain was so bad that he called his physician, Dr. Lum.

After Dr. Lum looked at the knee, he referred Mr. Gonzales to Dr. Rasmussen. She took him off work and prescribed pain medication. His knee continued to be painful and kept locking. Dr. Rasmussen recommended surgery but Mr. Gonzales had to wait a few weeks to get approval. About a month after the accident, he had knee surgery. The doctor cut holes in the side of his knee and found his knee "all torn on the insides." Dr. Rasmussen had to remove cartilage and other debris.

After the knee surgery, Mr. Gonzales went to physical therapy for months. Eventually, the knee started getting better and he talked to Dr. Rasmussen about returning to work. She permitted him to return to work on light duty with no lifting and limited walking. Because of his injury, Mr. Gonzales knew he would not be able to operate certain machines, due to the vibrations. On some machines, the seats didn't have a shock absorber, the operator space was crammed, and the transmission was not automatic. He believed riding these machines would hurt his knee. So, Dr. Rasmussen restricted his operation of certain types of equipment.

When he returned to work in light duty in about August 2001, his supervisor assigned him to a big machine, a rough mower, that permitted him to stretch his legs; it also had an automatic transmission. While he was operating that mower, his condition did not worsen. He would experience some stiffness and slight pain of about 3 or 4, out of 10. The pain still bothered him.

Several months later, a new superintendent arrived and assigned him to another rough mower, while he remained on light duty. This mower still had an automatic transmission but the seat wasn't cushioned; it was "really bouncy." Then, the superintendent assigned him to a Sand Pro that swept the sand traps and was bumpy. He had to operate both machines during the day. After about a week on these machines, with the pounding, he started having problems. He told his supervisor that something was wrong. However, because he needed the money, Mr. Gonzales generally kept quiet. When he mentioned the change to Dr. Rasmussen, she told him to keep trying. Within a week, his knee pain started increasing. His knee would be swollen at the end of the day and he couldn't sleep due to the pain. Some times at work, he wanted to stop

due to the pain, but he continued. Occasionally, he would go home and lie down on the floor. When the knee pain became really bad, Dr. Rasmussen would give him a knee injection. He continued to take pain medication.

After the transfer to the other machines, Mr. Gonzales' back also started to hurt. Due to the pain in his leg, Mr. Gonzales started to limp and he developed back pain in the low back area where he had surgery. The pain was in the middle of the back below the belt line and went down to the tail bone. The back pain also started radiating down his legs.

His pain was worse after long hours on the machines. Whenever Mr. Gonzales would try to take a break, "somehow the superintendent was around and says, 'What are you doing? Get back to work.'" Mr. Gonzales tried to explain his light duty status included the need for rest breaks. Many times, Mr. Gonzales also told the superintendent about his problems with the other machines, but he wouldn't listen. The superintendent would just smile and tell him to go back to work.

When the superintendent assigned him to a dump truck, Mr. Gonzales refused. Due to the vehicle's height, he couldn't get in it.

Mr. Gonzales went to Dr. Rasmussen to be taken off work since he couldn't stand the pain. When she didn't respond, Mr. Gonzales went to Dr. Hager on the advice of Mr. Birnbaum in August 2002. Mr. Gonzales presented his back problems to Dr. Hager who ordered an MRI and then took him off work. By that time, Mr. Gonzales had already left work.

Mr. Gonzales was then referred to Dr. Smith for treatment of his back. After the examination, Dr. Smith stated he would inform Dr. Hager of the results. Mr. Gonzales does not know what Dr. Smith diagnosed. While he really doesn't have any plans for his back, Mr. Gonzales is <u>not</u> interested in another surgery.

After Mr. Gonzales stopped working, the symptoms in his left knee remained the same. He uses a cane because his knee has collapsed a couple of times, causing him to fall. He was home alone during one of the falls. The incident scared him. Dr. Rasmussen has prescribed a knee brace, which Mr. Gonzales uses all the time.

While his back still hurts, it feels better since leaving work. However, his knee bothers him, which causes him to limp, which in turn bothers his back. His knee pain has changed; it is no longer burning. It still swells when he walks around and stands on his feet. He also has some pain in his right knee. "Just walking around is painful." Sitting is also difficult because he can't fully bend his knee. He also has trouble walking over uneven ground. The golf course where he used to work was hilly in some places and sandy. Because of his knee, Mr. Gonzales couldn't walk in those areas.

After returning to work following the left knee injury, Mr. Gonzales' back didn't bother him until the new superintendent placed him on the smaller machines. Due to his low back condition, he has problems bending. Over the past week, the pain in his back has been about level 7 or 8. He gets some relief when he lies on the floor and he'll gradually go to sleep.

Mr. Gonzales' sleep is interrupted by pain. He thinks moving in his sleep causes pain in his leg and back. So, he sleeps in a recliner and does not get a full night sleep. At most, he sleeps about three hours. Heat treatments provide some relief. He takes muscle relaxant medication and tries to exercise.

On the day Mr. Gonzales decided he couldn't go back to work, he felt a "funny feeling" in his left side of his neck and down, all on the left side. He believes the machine "banging" and vibrations have caused his problems. He first started feeling the sensations when he was working.

Mr. Gonzales would like to do whatever it takes to get better. He is presently receiving workers' compensation for his left knee. Since his knee surgery, Mr. Gonzales has gained weight because he can't exercise. In turn, the extra weight is hard on his knee and back.

Because of his back problems alone, Mr. Gonzales does not believe he can return to work. Just sitting in the hearing was painful. If he only had a knee problem, he could probably go back to work, but not the same job on the golf course due to the hills. So, it's his back and the combination of his back and knee that has put him out of work.

Mr. Gonzales enjoyed his old job; he liked getting up in the mornings and working on the golf course. He had friends at work. Staying at home is boring. Mr. Gonzales feels bad not earning an income for his family. He would like to go back to work but does not believe he can.

His employer sent a checker job to Dr. Rasmussen for her approval. The work occurred only three days a week. Additionally, the position involved a downgrade and he would go from $13 to $6 an hour. According to Mr. Gonzales, "I couldn't afford that." Dr. Rasmussen approved his return to that job. Later, he got an offer for a 40 hour a week job as a checker. He took that offer to Dr. Rasmussen and she was surprised that they had asked her about three days a week and then sent him a full time job. Mr. Gonzales did not think he could handle full time work. Later, near the end of 2002, he got a letter saying the job would be on Friday, Saturday and Sunday, starting at 7:30.

The letter is dated November 18, 2002 (EX 25) and indicates the Employer's belief that he was no longer capable of operating a vehicle. Instead, he was offered a checker position at $6 an hour, for 40 hours a week. That position was a clerical job and Mr. Gonzales did not want to get involved with that type of job because he was the union's chief steward for the entire Marine base for non-appropriated fund workers, until he left. He would have lost his union membership if he took the position because it was a non-union job. Mr. Gonzales is not aware of whether the Employer knew about that problem.

Mr. Gonzales showed Dr. Hager the job position. Due to his knee and back, the physician recommended that he go on disability.

Mr. Gonzales neither accepted nor rejected the job formally. He believes the Employer created the checker job for people who have injuries. Someone was doing that work 40 hours a week before he left. The guy in the position was a union steward and Mr. Gonzales wondered

how he was able to take that job. Apparently, he didn't realize it was a problem until Mr. Gonzales told him. The other employee stopped being a checker and went back to his other job.

[Cross examination] As the chief steward, Mr. Gonzales did not believe he was well liked. The new superintendent didn't like him.

Over the course of his employment with Marine Corps MWR, his annual appraisals were excellent.

Prior to his injury, Mr. Gonzales was in Classification 5 which permitted operation of small machines. Classification 6 involved the use of larger machines. A person in a Classification 6 job received more pay. After his injury, Mr. Gonzales operated the larger Classification 6 machines; the extra room helped his knee. The new superintendent indicated that since Mr. Gonzales was in Classification 5, he should not be operating the Classification 6 equipment.

Mr. Gonzales does not remember how often he told the superintendent about his knee problem due to the equipment vibration, but he did tell him and showed him the swollen knee. The superintendent made no response; he just walked away.

Dr. Rasmussen approved his use of the vehicles with a cushioned seat and automatic transmission.

In 2002, he mentioned to Mr. Mirata that he might retire in September. He changed his mind due to his uncertainty about coverage for his injury. In 1999, he asked the Employer for information about early retirement after the Employer indicated that opportunity was available.

When Dr. Rasmussen returned him to work, her restrictions included no bending, climbing or kneeling. The old superintendent accommodated Mr. Gonzales' condition by approving his operation of the machines that were most comfortable for him without regard to his classification. When the new superintendent arrived, he told Mr. Gonzales he should only be on Classification 5 machines.

Mr. Gonzales doesn't know what "cumulative injury" means.

Mr. Gonzales didn't go to Dr. Hager because he was unhappy with Dr. Rasmussen. He still sees Dr. Rasmussen. She prescribed the knee brace that he is wearing. After he saw Dr. Hager, Mr. Gonzales never returned to work. Instead, he followed Dr. Hager's advice to retire with a disability.

[ALJ examination] Mr. Gonzales' present back problem is located down by his tail bone, on the spine and mostly on the left side. The pain travels up to his neck. On the low side, the pain is persistent, sharp pain. When he experiences pain in the left side of his neck, he has numbness down his arms into the palms of his hands. The sensation occurs more often on the left side, usually when he tries to do a lot of walking. His right leg is "okay."

Mr. Gonzales stopped being a union steward on the day he retired, November 25, 2002. He last worked on Kaneohe in the summer of 2002. After he left work, Mr. Gonzales no longer knew whether the Employer needed a checker.

Mr. Gonzales viewed the reduction in pay from $13 an hour to $6 as a bad thing. He didn't contact the Employer about his concerns relating to his employment as a checker because the job information was sent to Dr. Rasmussen and not him. The letter he received discussed a 40 hour a week job. Mr. Gonzales did not respond to the letter.

At one time, Dr. Ma had treated Mr. Gonzales' back problem. Dr. Rasmussen took care of his knee. Upon his return to light duty, Mr. Gonzales did not experience any problems until he was switched to the other machines. He wasn't supposed to be on the larger machine but the seat cushioned the bumps. Even though he was riding Classification 6 equipment, Mr. Gonzales did not receive the extra pay for that grade. However, when the new superintendent arrived, he indicated Mr. Gonzales could no longer operate the Classification 6 vehicles because he was only a Classification 5. Mr. Gonzales explained that he need the "cushy seat" but the new superintendent said Mr. Gonzales had to stay on the Classification 5 equipment.

During his employment at Marine Corps MWR, Mr. Gonzales had operated the Classification 5 equipment many times. He usually split his time between the two types of classification machinery. He never had any problems with the Classification 5 equipment before his left knee injury. After injury, the vehicles' pounding and cramped area bothered his left knee, which also affected his back. He did not suffer any traumatic injury to his back.

[Re-direct examination] Mr. Gonzales believes his limping has contributed to his back problems. Mr. Gonzales limped even before he had to go back on the Classification 5 machines. Since leaving the mowing work, his back continues to hurt.

Mr. Gonzales got a 40 hour a week checker job offer from the Employer.

Mr. Gonzales' performance appraisal for May 2002 (EX 18) was satisfactory rather than excellent. When he got that appraisal, the new superintendent had been in place about four months. When he asked about the rating, the superintendent stated that was the way he evaluated it.

When Mr. Gonzales retired, he received an appreciation certificate and a years of service pin. Mr. Gonzales did not take the early retirement because he did not like the terms.

The rough mower was a problem for his knee because it had a panel right in front and he couldn't stretch his legs. The awkward position also hurt his back. Other than regularly scheduled breaks and lunch, Mr. Gonzales was on the machine about four hours straight and then he would be assigned to the Sand Pro vehicle. The Sand Pro was a problem because it was shaped like a turtle and the operator had to step over the middle to get his leg on the other side. It was like riding horse. His problem was getting on and off, which occurred quite often because the operator had to remove the rakes from the sand traps before running the machine over the sand. He would do all the traps for the eighteen holes in four hours.

All the machines had vibrations but the smaller ones were worse. He first really noticed the vibration about four or five years ago. Mr. Gonzales discussed the machines with Dr. Rasmussen before she set out his work restrictions (*see* EX 19). He specifically told her that he could not climb into the cab of the dump truck. He told the doctor about the other machines that she identified. He is not sure why she put down the Sand Pro because he told her that the vehicle caused him problems. At the same time, she must have gotten the information that he could operate it from him. Her reference to the rough cut mower is the bigger machine. He had problems on the smaller rough mower, which doesn't have the cushioned seat and has all the pounding.

[Re-cross examination] Mr. Gonzales' signature is on page 2 of EX 27 and he checked the box. Mr. Gonzales received a copy of EX 25 in the mail. He did not return any portion of the document to the Employer. He retired instead.

[Re-direct examination] Mr. Gonzales did not complain to Mr. Cazinha about having to drive the Classification NA-6 equipment. Mr. Gonzales told Mr. Cazinha that on the larger tractor he was able to stretch his leg out and the seat had "flotation," which was better for him. No one told him that he was taken off the machine because he hit various objects. Everyone seems to hit things on the tractor; "it happens, it's an accident."

Mr. Todd P. Mirata
(TR, pages 217 to 234)

[Direct examination] Mr. Mirata works at the Kaneohe Bay Marine Corp base golf course. He has been the golf course manager for the past four years and supervised Mr. Gonzales.

At the time of his knee injury, Mr. Gonzales' job classification was NA-5. He was in the same classification on the date of the alleged second injury. For a "short period of time," Mr. Gonzales was permitted to operate a pull tractor that would be classified under NA-6. They did not intend for him to remain in that position for "a long duration."

Even when he was on the large equipment, Mr. Gonzales would also still drive the smaller NA-5 vehicles, including the Sand Pro and small rough mower. Shortly after he arrived, the new golf course superintendent, Mr. Cazinha, told Mr. Mirata that Mr. Gonzales should not be operating the larger equipment; Mr. Cazinha wanted him to only operate the smaller equipment. Mr. Cazinha expressed a concern that letting Mr. Gonzales work in the higher classification would displace another NA-6 employee and Mr. Gonzales might be able to get the classification permanently. The NA-6 position warranted higher pay because it carried more responsibility.

Mr. Mirata was Mr. Cazinha's supervisor. However, Mr. Mirata had daily contact with Mr. Gonzales. Mr. Gonzales never complained to Mr. Mirata about any pain when he was driving the equipment. He never expressed any concern about being unable to work as an NA-5. If he had expressed any problems with not having his restrictions accommodated, Mr. Mirata would have taken action and worked with personnel to ensure they were doing the right thing.

When Mr. Gonzales presented his physician's restrictions, Mr. Mirata worked closely with personnel to ensure they were accommodating his "needs consistent to the doctor slips." He believes union stewards are accommodated more than other employees due to their union status.

The large pull tractor operated by Mr. Gonzales had a clutch and required a person to climb 2 to 3 feet to get into the operator seat. Comparably, it was as high as the dump truck.

During Mr. Mirata's four years at the golf course, with one exception, Mr. Gonzales received satisfactory to excellent work evaluations. In 2001, due to an employee confrontation, he received an unsatisfactory rating.

[Cross examination] Mr. Gonzales started his work day around 5 in the morning. Mr. Mirata arrived between 8:30 a.m. to 9:00 a.m.; he works six days a week.

Mr. Cazinha left because he received a promotion. Mr. Mirata doesn't remember receiving any employee complaints about Mr. Cazinha.

Mr. Gonzales was not removed from the larger tractor due to any physical limitations. He had been allowed to work NA-6 equipment because the golf course was short-handed; it had nothing to do with his light duty status. Mr. Mirata is not aware that Mr. Gonzales requested the larger equipment. He may have asked Mr. Cazinha. Having a person stuck in a higher rated position is bad for management. Management is not permitted to put someone in a higher classification just to accommodate light duty status. Any reassignment to a higher classification is temporary and may not last more than three or four months.

Mr. Cazinha advised Mr. Mirata that he was taking Mr. Gonzales off the larger tractor. At that time, the short-handed situation had changed. When Mr. Cazinha arrived in the superintendent position, Mr. Gonzales had been operating the larger equipment two to three months. The prior superintendent had not complained about Mr. Gonzales driving the larger tractor. Mr. Mirata was not even aware there was a problem until Mr. Cazinha brought the situation to his attention.

Mr. Daryl M. Cazinha
(TR, pages 234 to 259)

From January 2002 to January 2003, Mr. Cazinha worked at the golf course as the superintendent and supervised Mr. Gonzales, who was an NA-5 vehicle operator. Mr. Cazinha knew Mr. Gonzales had previously suffered a work-related knee injury. When Mr. Cazinha arrived, Mr. Gonzales was on light duty status. The employees seemed to have their specific jobs, so while he was going through the learning process, Mr. Cazinha did not change anything. At that time, Mr. Gonzales was working the larger mower.

As Mr. Cazinha started going through the employees' job descriptions, he noted that Mr. Gonzales was an NA-5 machine operator but the larger tractor required an NA-6 operator. Mr. Cazinha specifically looked into Mr. Gonzales' situation because he had hit various objects and

damaged the mower that the tractor pulled. Because the mower is pulled, the operator has to constantly turn, watch it, and return to driving the tractor. "It takes a lot of concentration."

When mowing in the tall grass, the operator is required to inspect the area. Mr. Gonzales "ran over three control boxes, valves boxes, ripped them out of the ground on the 14th hole and created a leak." Mr. Cazinha let that incident pass. He instructed Mr. Gonzales to inspect the tall grass. However, a couple of weeks later, Mr. Gonzales "hit a tree stump." Mr. Gonzales explained that the stump had been there for 20 years and the golf course should have taken it out.

After the second incident, Mr. Cazinha started looking into Mr. Gonzales' operator qualifications. That's when he discovered that Mr. Gonzales, an NA-5 operator, was driving NA-6 equipment. Mr. Cazinha believed Mr. Gonzales should either get a promotion to NA-6 or stop driving the larger tractor. Operating the larger tractor should not be used for light duty. Additionally, Mr. Gonzales couldn't bend and get into the dump truck, which was just a little higher off the ground than the larger mower. So, Mr. Cazinha talked to Mr. Mirata. Since Mr. Gonzales' restrictions did not seem to preclude his driving the Sand Pro or smaller mower, Mr. Cazinha put him on the NA-5 equipment and assigned an NA-6 driver to the larger equipment. The NA-6 driver had been working on the smaller NA-5 machines.

In the mornings, Mr. Cazinha would assign Mr. Gonzales to the small rough mower and he would go cut the rough grass. At the end of the work day, as he was leaving, Mr. Gonzales might have mentioned twice that he had a sore knee after using the smaller machines. However, he also stated that he was going to physical therapy at that time. Mr. Cazinha told Mr. Gonzales to let him know if he still had any problems the next day. When Mr. Cazinha asked about the knee the next day, Mr. Gonzales said it was okay. So, Mr. Cazinha put him on the small mower. Other than the two knee complaints, Mr. Gonzales did not express any other concerns.

After he changed doctors, Mr. Gonzales presented a note "basically saying he couldn't do anything." In response, Mr. Cazinha presented the issue to Personnel who offered Mr. Gonzales a checker's job, checking receipts. Mr. Cazinha believes Mr. Gonzales declined the offer.

Mr. Cazinha gave Mr. Gonzales a satisfactory rating. According to Mr. Cazinha, "he was doing good being on light duty."

[Cross examination] On the performance report, Mr. Cazinha was attempting to convey that, while on light duty, Mr. Gonzales was still doing his NA-5 job satisfactory.

Based on Mr. Gonzales' statements to him, Mr. Cazinha believed Mr. Gonzales was driving the larger tractor because of his work restrictions. Looking at Mr. Gonzales' work restrictions, Mr. Cazinha noted that he should not be climbing into the dump truck and that the large rough cutter stood nearly as high as the dump truck. That similarity, coupled with the other work restrictions, was one of the reasons Mr. Cazinha talked to Mr. Mirata about taking Mr. Gonzales off the larger tractor. Mr. Cazinha pointed out to Mr. Mirata that based on the written work restrictions, Mr. Gonzales couldn't get on the dump truck. Also, he was doing NA-6 work. In Mr. Cazinha's opinion, they should either pay him as a NA-6 or put him back to NA-5. At the

same time, Mr. Cazinha probably took Mr. Gonzales off the larger mower because he didn't want him hitting any additional objects.

Mr. Gonzales did not object when he was taken off the large mower. Previously, Mr. Gonzales had told Mr. Cazinha that the tractor allowed him to stretch out his legs.

On one occasion, Mr. Gonzales started a conversation with Mr. Cazinha about a work problem and then changed the subject to a union matter. Mr. Cazinha stopped him and told Mr. Gonzales to make a specific appointment to discuss the union issue because they have to set aside a specific time for union matters. In union conversations, Mr. Cazinha likes having another person present.

Radiology Report
(EX 51)

A radiologist reported that a September 27, 1986 x-ray showed degenerative changes in the lower lumbar spine.

Dr. Edward B. Lipp
(EX 51)

On July 3, 1991, Dr. Lipp evaluated Mr. Gonzales for persistent lower right quadrant pain. As part of his evaluation, the physician noted that x-rays of the lumbosacral area revealed surgical fusions at L4-5 and L5-S1 with some "radiolucency evident at the fusion sites." His diagnosis was lumbar disc syndrome.

Dr. Steven M. C. Lum
(CX 4, CX 12, EX 1, EX 33, and EX 35)

On February 3, 2001, Dr. Lum evaluated Mr. Gonzales for a health issue unrelated to any injuries. His medical history included back surgery in 1969. Mr. Gonzales reported "he still gets pain now and then if he stresses his back." On physical examination, Dr. Lum noted Mr. Gonzales had "free" range of motion of his extremities.

On June 5, 2001, having selected Dr. Lum as his choice of physician, Mr. Gonzales presented to Dr. Lum with a swollen and painful left knee. On June 1, 2001, he had slipped on wet metal and twisted his knee. He had been trying to walk but the knee was not getting better and was locking. Dr. Lum noted tenderness on the medial aspect and referred Mr. Gonzales to Dr. Rasmussen for evaluation of a possible meniscus tear.

On June 21, 2001, Mr. Gonzales reported continued left knee pain which interfered with his sleep. Knee surgery was scheduled for the next day. Mr. Gonzales was also having problems in his low back area due to favoring his left knee. The left knee remained tender upon palpitation.

On July 24, 2001, Mr. Gonzales reported slow improvement in his left knee after surgery.

On August 8 and August 14, 2001, Dr. Lum reported Mr. Gonzales continued to do better. His left knee was in a brace.

Mr. Gonzales reported renewed left knee pain on November 20, 2001. His back was also hurting. Upon examination, the left knee appeared slightly swollen. Dr. Lum diagnosed left knee and lower leg edema secondary to soft tissue strain and trauma.

Dr. Linda J. Rasmussen

Medical Treatment Notes
(CX 4, CX 14, and EX 36)

On October 18, 1989, Mr. Gonzales saw Dr. Rasmussen, board certified in orthopedic surgery,[4] after twisting his right knee while riding a machine. An emergency room x-ray showed no bones were broken.[5] Two days later, when he saw the physician, Mr. Gonzales was experiencing tightness and discomfort in the knee. After Dr. Rasmussen found moderate effusion, she removed some of the fluid from the knee joint. The physician placed him in a knee brace and diagnosed a possible meniscus tear.

On November 28, 1989, Mr. Gonzales was doing well. He only experienced some stiffness and occasional discomfort in the right knee. While examination revealed some medial line tenderness, no mechanical symptoms were noted and the ligaments were stable.

On February 20, 1991, Mr. Gonzales reported suffering low back pain after using a weed eater. Since disc surgery in 1969, Mr. Gonzales had not experienced any problems with his back. Physical examination found tenderness in the lower lumbar region and limited range of motion. An x-ray showed the inter-body fusion at L5-S1 and some narrowing at L4-5. Dr. Rasmussen diagnosed lumbar strain and recommended a return to back exercises and the avoidance of bending or lifting.

Mr. Gonzales returned on July 15, 1997 after one week of right knee pain along the medial line. The pain had started after a "hard day using a chain saw to cut trees" at the golf course. The right knee had full range of motion with some medial joint line tenderness. No effusion was present. Dr. Rasmussen diagnosed a possible medial meniscus tear. However, due to the infrequency of the knee pain, she suggested giving the knee some time to settle down to see if it would heal. If the pain did not diminish, she anticipated an MRI might be necessary.[6]

On August 7, 1997, Mr. Gonzales reported that his right knee pain had improved. He did not experience any locking. Some pain was noticeable upon deep knee bends. Dr. Rasmussen diagnosed medial collateral ligament strain.

---

[4]As I informed the parties at the hearing (TR, pages 5 and 6), I take judicial notice of Dr. Rasmussen's board certification and have attached the certification documentation.

[5]*See also* Castle Medical Center treatment statement signed by Mr. Gonzales on October 16, 1991 (EX 51).

[6]*See also* Dr. Hahn's September 1997 workers' compensation report (EX 51).

On August 28, 1997, Mr. Gonzales stated about a week earlier he had experienced an episode of his right knee locking. He experienced a rapid onset of pain and inability to bend his right knee. He moved the knee around until he heard an audible snap. The physical examination disclosed only mild effusion. However, Mr. Gonzales had significant medial collateral ligament pain upon stressing the knee. Dr. Rasmussen ordered an MRI.[7]

On June 5, 2001, Mr. Gonzales presented to Dr. Rasmussen with a painful and swollen left knee. Mr. Gonzales twisted his left knee when he slipped on a wet metal surface getting onto a tee mower. As the knee twisted, he heard a "cluck," Since the accident, his knee has swollen, clicks and occasionally locks so that he can't straighten it. Upon examination, Dr. Rasmussen noted Mr. Gonzales limped, displayed moderate discomfort, and had a swollen left knee. She found medial joint line tenderness and clicking with loading of the medial meniscus. The left knee x-rays revealed "no significant underlying degenerative change. No significant joint-space narrowing." Dr. Rasmussen diagnosed medial meniscus tear and recommended arthroscopic surgery. To preclude further damage, the physician took Mr. Gonzales off work.

Mr. Gonzales returned on June 19, 2001 with continued left knee pain and rigidness. His knee kept locking, interfering with his ability to move around. Due to his limping, Mr. Gonzales was developing back pain. He was frustrated with the delay in getting his knee fixed. Dr. Rasmussen found a locked knee and again recommended prompt surgery. The physician disagreed with the delay and cost associated with an MRI requested by the insurance company. Dr. Rasmussen believed appropriate care was being compromised by the delay and noted that Mr. Gonzales' "back is now being affected directly as a result of him limping with respect to his knee."

On June 22, 2001, Dr. Rasmussen conducted arthroscopic surgery on Mr. Gonzales' left knee. In the pre-operative evaluation, the physician noted Mr. Gonzales ambulated with a limp, "favoring his left leg with an antalgic type gait." He was unable to straighten his left leg. The diagnosis was left knee medial meniscus tear with locked knee. Once Mr. Gonzales was put to sleep, the surgeon was able to straighten out his knee. During the procedure, she observed a contusion on the central part of the articular cartilage under the patella. The medial compartment revealed an unstable posterior horn medial meniscus tear, a loose piece of meniscus, and a tear involving the anterior horn of the medial meniscus. The torn parts and loose piece were removed. The meniscus was shaved smooth. Some mild degeneration or fraying of the articular cartilage was also observed.

On July 2, 2001, Mr. Gonzales was recovering nicely from his left knee surgery and partial meniscectomy. Though his left knee felt better, some moderate effusion was still present. Dr. Rasmussen referred him to physical therapy.

When Mr. Gonzales returned on July 26, 2001, he still had some stiffness and swelling, which became more pronounced with activity. Physical therapy was helpful. He wanted to get back to work but was concerned about its physical demands, which required a stable knee. The

[7]The copy of Dr. Rasmussen's medical treatment notes contains no other information about the resolution of Mr. Gonzales' right knee problem. The next entry is June 5, 2001.

left knee continued to have mild to moderate effusion. He had full extension and no instability. Dr. Rasmussen anticipated returning Mr. Gonzales to work on August 27, 2001.

By August 23, 2001, Mr. Gonzales stated his knee was doing better. At the same time, while he was progressing with physical therapy, Mr. Gonzales did not feel strong. Nevertheless, he requested to return to work the next week. According to Mr. Gonzales, the Employer would permit him to operate a tractor that does not require him to get on and off. Upon observation, the knee had mild swelling.

On September 19, 2001, Mr. Gonzales reported problems with his left knee buckling when he "gets off the tractor." He was progressing well in physical therapy and his pain situation was improving. He continued to work light duty. Dr. Rasmussen found no significant swelling and full extension of the left leg. Some quad muscle atrophy was present. She planned to let Mr. Gonzales return to full duty at the end of October 2001.

When Mr. Gonzales returned on November 19, 2001, his left knee had been problematic for about a month. He suffered occasional swelling, mild to moderate pain, and buckling. His symptoms were activity-related. Mr. Gonzales continued in light duty status. He did not believe he could return to regular work because of the physical demands associated with getting on and off the equipment. Upon examination, Dr. Rasmussen observed a normal gait and minimal swelling in the left knee. The doctor diagnosed chondromalacia patella.[8] She went over the prescribed exercises and commented that he was "actually doing some things that are aggravating the knee." Dr. Rasmussen administered some cortisone injections in the left knee to "settle things down."

On January 23, 2002, Mr. Gonzales reported only limited effectiveness with the knee injections and resulting back pain. His knee cap was still painful and the knee occasionally buckled. Other than tenderness at the patellofemoral joint, the left knee exam was normal. Mr. Gonzales' gait was normal. Dr. Rasmussen diagnosed left knee chondromalacia patella. She believed some of the buckling was attributable to muscle weakness.[9] She recommended continued work on quad strengthening and additional physical therapy. He remained on light-duty.

On April 9, 2002, Mr. Gonzales, who continued to work part-time, had a lot of left knee pain. A new STS treatment had alleviated the pain and he was encouraged. He was not able to get on and off tractors and had difficulty "doing anything where he has to step up or anything that involves hills or walking." The examination showed Mr. Gonzales in moderate discomfort with mild left knee swelling. He achieved full extension with "significant pain." Dr. Rasmussen diagnosed left knee synovitis[10] with underlying chondromalacia patella. She believed his problem related to inflammation and switched his anti-inflammatory medication. The doctor

[8]Softening of the articular cartilage at the knee cap. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 321, 1243 (28th ed. 1994).

[9]Part of Mr. Gonzales' physical history included an overweight condition.

[10]Inflammation of a joint cavity membrane. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1645 (28th ed. 1994)

also administered another cortisone injection and prescribed additional physical therapy and STS treatment. Dr. Rasmussen opined that unless the inflammation was brought under control, Mr. Gonzales would not be able to return to his regular duties.

On June 6, 2002, Mr. Gonzales reported continued left knee pain associated with activities. He had difficulty squatting and stressing his flexed knee. Physical therapy only provided temporary relief. Due to nausea, Mr. Gonzales stopped taking anti-inflammatory medication. Dr. Rasmussen observed a slight limp favoring the left knee. The left knee exam was generally normal with the exception of patellofemoral joint pain. A knee x-ray showed mild joint space narrowing in the medial compartment and patellofemoral joint. Dr. Rasmussen diagnosed mild DJD (degenerative joint disease). Although the knee injections seemed to have resolved the synovitis, Dr. Rasmussen reported Mr. Gonzales' work restrictions would remain permanent. She also administered another injection.

On August 27, 2002, Mr. Gonzales presented with continued left knee pain and reported a flare-up after the last knee injection, followed by temporary relief. Over time, his pain returned. Mr. Gonzales reported he was off work and that Dr. Hager had diagnosed some pinched nerves in his back. Dr. Rasmussen observed, "the patient feels very strongly that the limping related to his left knee has resulted in his back becoming flared. He actually has very strong feelings and is quite angry with the insurance company." Dr. Rasmussen observed a limp favoring the left knee. Other than pain with full extension, the left knee was essentially normal. The physician was uncertain of the etiology of the knee's range of motion problem. She recommended continued quad muscle exercise and anti-inflammatory medication. Mr. Gonzales declined another cortisone injection.

On January 13, 2003, Mr. Gonzales stated that his left knee had been bothering him more after doing a lot of walking. He had retired in November 2002. On the day of the examination, his left knee was sore. Mr. Gonzales did not report any problems with his knee giving out; his principle concerns were pain and swelling. Dr. Rasmussen noticed a limp; the left knee had mild swelling and effusion. Mr. Gonzales was 5 degrees short of full extension of the left leg. Dr. Rasmussen diagnosed underlying degenerative joint disease with synovitis and inflammation. She administered a cortisone injection and recommended continued quad muscle strengthening.

Personnel Notes
(CX 3, CX 8, CX 9, CX 13, CX 15, EX 15, EX 17, EX 19, EX 23, EX 24, and EX 36)

On June 5, 2001, Dr. Rasmussen informed Marine Corps MWR that Mr. Gonzales would be off duty for one month due to a June 1, 2001 accident. On June 6, 2001, she added that he would probably need another two or three months off work after surgery.

On June 8, 2001, Dr. Rasmussen requested authorization from the Insurer for arthroscopic surgery of the left knee.

On June 19, 2001, Dr. Rasmussen informed Marine Corps MWR that Mr. Gonzales needed arthroscopic surgery as soon as possible. She diagnosed a torn cartilage which caused his left knee to lock. That problem caused Mr. Gonzales to limp which was also causing low back

pain. Any delays associated with approving the treatment would "compromise" the outcome of the operation.

On July 26, 2001, Dr. Rasmussen indicated Mr. Gonzales may return to work on August 27, 2001.

On August 23, 2001, Dr. Rasmussen indicated Mr. Gonzales could return to work effective August 29, 2001. However, she imposed the following limitations: no lifting items greater than 20 pounds; no kneeling; no lifting, no squatting or climbing more than one hour a work day; and, no bending for more than two hours. Dr. Rasmussen anticipated the restrictions would end September 17, 2001 and Mr. Gonzales would reach maximum medical improvement ("MMI") at that time.

In response to a September 18, 2001 letter from the Insurer, Dr. Rasmussen indicated that Mr. Gonzales remained on light duty and was not scheduled for a re-evaluation until the end of October 2001. As a result, the physician did not believe he had reached MMI on September 17, 2001, as she had previously anticipated. Instead, the doctor anticipated his disability would become permanent and MMI would be reached on December 1, 2001.

On March 28, 2002, a physical therapist indicated that while Mr. Gonzales was undergoing additional physical therapy prescribed by Dr. Rasmussen, he should continue his light duty status through at least April 9, 2002.

On April 9, 2002, Dr. Rasmussen continued Mr. Gonzales' light duty restriction for another month. The doctor also presented a treatment plan for Mr. Gonzales' left knee synovitis and chondromalacia patella consisting of cortisone injections and physical therapy through July 7, 2002.

On June 4, 2002, Dr. Rasmussen imposed the following limitations on Mr. Gonzales' work: no squatting, climbing or kneeling; no lifting greater than 20 pounds; no carrying greater than 15 pounds; no walking or lifting for more than one hour; and no bending or standing for more than two hours. She specifically noted that he could operate the rough mower and Sand Pro but could not climb into the dump truck. Dr. Rasmussen listed the date of maximum medical improvement as September 17, 2001.

On November 6, 2002, after reviewing Dr. Ma's evaluation and the motor vehicle operator job description, Dr. Rasmussen informed Marine Corps MWR that Mr. Gonzales was able to work as a motor vehicle operator within her restrictions. The next day, November 7, 2002, Dr. Rasmussen also indicated Mr. Gonzales was physically capable of working as an I.D. checker at the golf course.

Physical Therapy Notes
(CX 1, CX 10, CX 11, and EX 37)

Based on a referral from Dr. Rasmussen, between July 9, 2001 and August 22, 2001, Mr. Gonzales received physical therapy sessions about three times a week to improve leg muscle

strength. Typically, he complained about a swollen left knee in the mornings which seemed to improve as the day proceeded. On a few occasions, his left knee would buckle walking down steps or on incline. After one session, Mr. Gonzales reported both knee and back pain. Towards the end of the sessions, Mr. Gonzales reported some improvement; however, he was worried about returning to work and continued to experience swelling in his knee.

From January 28, 2002 through April 3, 2002, Mr. Gonzales again received multiple physical therapy sessions. He presented with a painful and swollen left knee, coupled with complaints of buckling going down stairs. On February 1, 2002, Mr. Gonzales was unable to go to work due to a painful and swollen left knee. Half way through the sessions, Mr. Gonzales reported grinding under his knee cap and associated pain. The swelling in the left knee would become more pronounced after extensive activity. At the end of the treatment regime, Mr. Gonzales reported improvement, particularly with medication and STS treatments.

Dr. Gabriel W.C. Ma

Medical Evaluation Notes
(EX 42, EX 48, EXC 49, and EX 50)

In March 1973, Dr. Ma evaluated Mr. Gonzales' low back abnormal sensations. Dr. Ma concluded Mr. Gonzales was not worse off than after the 1970 surgery. X-rays indicated the spinal fusion was solid. Mr. Gonzales had reached a stationary status and could expect to experience occasional low back ache and some limitations in range of motion. Dr. Ma recommended Mr. Gonzales be permitted to continue working and did not anticipate the need for additional surgical treatment of his back.

On July 12, 2002, Dr. Ma examined Mr. Gonzales, who was a golf course maintenance worker. Mr. Gonzales had suffered a left knee injury in June 2001. During the subsequent arthroscopic surgery, "obvious arthritic changes of the undersurface" of the left patella and a meniscus tear were noted. A partial meniscectomy was performed. Following physical therapy, Mr. Gonzales stated that he continued to suffer left knee pain and swelling.

Dr. Ma noted a left-sided limp and apparent left knee discomfort. Upon palpitation, and external rotation, Mr. Gonzales experienced pain over the medial joint line. Crepitation of the underside of the patella indicating chondromalacia was evident. Left knee flexion and extension were less than normal. The left knee and its ligaments were stable. X-rays of the left knee disclosed "obvious early medial compartment arthritis;" the same condition, to a minor degree, was present in the right knee.

Based on his evaluation and the radiographic evidence, Dr. Ma concluded that Mr. Gonzales had persistent left knee pain with reduced range of motion. "As such, I do not feel he has reached maximum medical improvement." For further improvement, Dr. Ma recommended either a sports medicine consult to increase range of motion and decrease intermittent swelling or additional orthopedic surgery treatment. If Mr. Gonzales did not pursue such referrals, then Dr. Ma believed he had "reached maximum medical improvement for the work-related injury of 6/1/01." In that case, his left knee condition was permanent and stationary. Based on the Fifth

Edition of the AMA (American Medical Association) disability guidelines, the permanent condition represented a 20 % impairment of the left lower extremity due to the range of motion limitations. In light of his left knee impairment, Mr. Gonzales should not return to his usual and customary job. Instead, Dr. Ma recommended light duty with appropriate restrictions.

Dr. Ma reviewed the May 2002 spinal CT scans. According to Dr. Ma, the cervical study showed a degenerative and herniated C6-7 disc, with some minor neural encroachment. The thoracic study revealed "multiple-level facet arthritis with no significant encroachment." With the exception of the L4-5 surgery site, the lumbar spine appeared normal.

On January 13, 2003, Dr. Ma reviewed a January 6, 2003 note from Dr. Hager and a July 2002 progress report from Dr. Rasmussen. He then evaluated Mr. Gonzales for his back condition. Mr. Gonzales described his back injury and surgery histories. He then explained that the April 10, 2002 incident date reflected his new boss' decision to assign work that exceeded Mr. Gonzales' light duty restrictions. No injury actually occurred on April 10, 2002. Instead, his work aggravated his condition and led to back, neck and upper extremities pain. Specifically, Mr. Gonzales had pain in the base of his neck and forearms with tingling sensation in his fingers bilaterally. He had pain in the left low lumbar area just lateral to the surgical site. Both feet would become numb. Mr. Gonzales experienced severe left knee pain that caused him to limp.

Upon examination, Mr. Gonzales demonstrated limited range of motion in his neck. Although slow, he appeared to have full range of motion of his upper extremities. His muscle size, tone and jerks were normal. His hand grip was normal. Mr. Gonzales expressed bitter tenderness in the low back area. "Straight leg raising was considered normal, producing pain in the backs of the knees but not in the low back." The right knee examination was consistent with moderate arthritis.

Based on the medical record review, radiographic evidence, and examination, Dr. Ma diagnosed pre-existing degenerative and herniated C6-7 disc with cervical spondylosis;[11] recovered left shoulder strain; "minor residual pain and minimal neurological deficit" at the back surgery site. His conditions represented "minor" and "temporary" aggravation of pre-existing conditions due to work activity on or about April 10, 2002. Mr. Gonzales had reached maximum medical improvement for the aggravated conditions. Based on Mr. Gonzales' resentment of his Employer and the pre-existing physical problems, Dr. Ma doubted Mr. Gonzales could perform light duty without increased complaints from minor incidents. He recommended Mr. Gonzales be allowed to retire due to physical disability. Mr. Gonzales did not require any additional medical treatment; even the physical therapy prescribed by Dr. Hager was unnecessary.

[11]Degenerative joint disease affecting the vertebrae. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1564 (28th ed. 1994).

Hearing Testimony
(TR, pages 141 to 181)

[Direct examination] Dr. Ma, board certified in orthopedic surgery,[12] examined Mr. Gonzales twice. He first evaluated him on July 12, 2002. Mr. Gonzales presented with continued left knee pain and limited range of motion following arthroscopic surgery. According to Dr. Ma, Mr. Gonzales suffered an 8% whole body impairment, which represents a 20% disability to the left lower extremity. The physician believed the rating was high. Two possible disability rating systems were available. Dr. Ma used the procedure based on a flexion deformity that gave Mr. Gonzales the highest rating. If he had used the alternative rating system based solely on knee x-rays, Mr. Gonzales would have no impairment.

Dr. Ma doesn't recall Mr. Gonzales wearing a knee brace at the time of the first visit. He had an obvious, moderate limp on his left side because he can't straighten his left knee. Based on physical examination and x-rays, coupled with right knee pain complaints, Dr. Ma concluded Mr. Gonzales has degenerative arthritic disease in both knees. Mr. Gonzales' problems are more pronounced in the left knee due to his injury. Dr. Ma attributes the degeneration to genetics, size, and heavy duty work.

Dr. Rasmussen did not have an MRI accomplished prior to knee surgery. For patients Mr. Gonzales' age who have worked heavy labor, Dr. Ma usually orders an MRI to determine the extent of any degenerative arthritic changes. With that information, Dr. Ma is then able to advice patients about the outcome of the knee surgery.

At the July 2002 examination, Dr. Ma reviewed the medical record and concluded Mr. Gonzales had a "bad result" from the left knee surgery, due to the nature of his knee condition at the time of operation. Dr. Ma did not find any fault with Dr. Rasmussen. Dr. Rasmussen had indicated that the expected surgical outcome would not be as good as the result with a normal knee. Mr. Gonzales had predisposing damage to the undersurface of the medial femoral condyle and the upper part of the leg bone. Because Mr. Gonzales had a torn medial meniscus, Dr. Rasmussen rendered appropriate medical care.

Dr. Ma suggested a referral to a sports medicine specialist for another arthroscopic evaluation to determine if "there is anything else to be done on his left knee" before it was rated. At the time, he didn't know whether Mr. Gonzales had reached MMI; he simply suggested that Dr. Rasmussen consider the referral. As of the second visit in January 2003, no one else had examined Mr. Gonzales' left knee.

Dr. Ma is not aware of Dr. Rasmussen's physical restrictions for Mr. Gonzales.

Dr. Ma evaluated Mr. Gonzales again on January 13, 2003, because he had developed other complaints based on an incident on April 10, 2002. He complained about neck, back, and shoulder pain, with associated numbness in his fingers. In the previous July 2002 examination, even though Dr. Ma had asked him about any other problems, Mr. Gonzales had not mentioned

[12]With the Claimant's concurrence, I accepted Dr. Ma as an expert witness regarding orthopedic surgery (TR, pages 140 and 141).

any of the complaints that he later presented at the January 2003 evaluation. As part of this later exam, Dr. Ma reviewed one page of Dr. Hager's observations and three pages from Dr. Rasmussen. Dr. Ma observed that the April 10, 2002 incident date was the day Dr. Rasmussen released Mr. Gonzales to go back to work at light duty. No specific injury, accident, or incident occurred on that day. Apparently, Mr. Gonzales indicated he was doing work that he was not supposed to do.

Dr. Hager had done a CT scan of the whole spine in May 2002. Dr. Ma doesn't know why that procedure was conducted. The study detected an old pre-existing degenerated hernia of the C6-7 discs and some scarring at L4-5 from the 1969 back surgery. Other than some arthritic spurring, the thoracic spine was normal for Mr. Gonzales' age.

Dr. Ma does not believe Mr. Gonzales is totally disabled from any kind of work. Apparently, Mr. Gonzales had been happy with what he was doing at work until April 10, 2002. When he saw Mr. Gonzales in January 2003, Dr. Ma did not believe he needed any further treatment. Whatever had bothered him in April 2002 would have totally subsided within 12 weeks. He believed the April 10, 2002 date represented only a minor aggravation of a pre-existing condition.

[Cross examination] The Fifth Edition of the AMA disability guidelines evaluate arthritic changes in the medial compartment by measuring the distance between the low part of the femur and the upper part of the tibia. Based on x-rays, Mr. Gonzales has normal spacing in the left knee, which equates to zero disability.

Mr. Gonzales' moderate limp is connected to his left knee injury. His flexion limitations in the left knee contributed to the 20% impairment rating. No additional disability rating is warranted for the knee brace prescribed by Dr. Rasmussen.

Mr. Gonzales has crepitus in his right knee. Dr. Ma attributes some deterioration of the undersurface of the right knee cap to Mr. Gonzales' work. Additionally, the other arthritic changes in that knee occurred at least partly due to the work he did. Those problems were accelerated by his work and probably are irreversible. The physician doesn't know whether Mr. Gonzales will require medical treatment for the problem.

Concerning his permanent disability rating, Dr. Ma stated, "I did not want the rating to be definitive. I left the benefit of doubt for the patient's benefit and Dr. Rasmussen's benefit." Dr. Ma doesn't know whether another arthroscopy will benefit the left knee. There is a possibility of some improvement but "not a probability." In other words, there's a possibility something more in the joint might be discovered that explains the flexion problem.

Dr. Ma agreed that the severity of a person's limp can vary day to day. Mr. Gonzales' limp caused by his left knee injury put additional stress on his right knee and to some degree contributed to the changes in the right knee.

Dr. Ma didn't ask Mr. Gonzales about medication since he did not appear to be under narcotic or alcoholic influence during the history interview.

Concerning Mr. Gonzales' back, Dr. Ma stated, "His spine was fine. He had a solid fusion at L4 – 5 since 1969, and the CT scan did not show any damage to his spinal cord." Dr. Ma agreed the stresses of work may have contributed to the degeneration of Mr. Gonzales' spine. However, the doctor noted that deterioration of the spine occurs everyday through aging.

Sometimes a limp can place stress on the lower back. It is possible such stress occurred in Mr. Gonzales' case. If he is limping at work, it probably put additional stress on his low back. At the same time, based on Dr. Hager's CT scan, Dr. Ma doesn't think Mr. Gonzales sustained a very severe injury to the body part of spine from any specific incident in April 2002. Dr. Ma concluded that Mr. Gonzales aggravated a pre-existing, long-standing degenerative disc.

[Re-direct examination] After the January 2003 examination, Dr. Ma recommended the Employer let Mr. Gonzales retire. He made that recommendation because if the job hurt him so much, he should be allowed to retire.

Dr. Gilbert P. Hager

Medical Treatment Records
(CX 5, EX 26, EX 38, EX 52, EX 53, and EX 54)

On May 2, 2002, Mr. Gonzales presented with pain complaints concerning his neck, upper back, mid-back, low back and left knee. Following a low back injury and subsequent disc fusion surgeries, Mr. Gonzales had been able to return to work in 1970, but was laid off a year later. After vocational rehabilitation, Mr. Gonzales was employed by Marine Corps MWR in 1987 as a golf course maintenance worker. He was doing well until he suffered a left knee injury at work on June 1, 2001. Mr. Gonzales returned to work on modified duty three to four months after left knee arthroscopic surgery. However, he suffers residual pain in the low back and left lower extremity with limping and a vibration sensation. His pain level was 5 to 6, with aches in his back and a burning sensation in his knee. He reported physical therapy had not helped his knee very much. Mr. Gonzales had an antalgic gait with a "short left stance phase." The back was tender along the whole midline. Dr. Hager diagnosed left knee derangement, aggravation of low back pain by the work-related injury of June 1, 2001, and cervical-thoracic sprain also associated with the June 2001 accident. He intended to obtain spinal radiographic studies and attempt to rule out lumbosacral radiculopathy.

On July 18, 2002, an EMG test disclosed an abnormality consistent with mild acute motor radiculopathy at S1 on the left.

On August 22, 2002, Mr. Gonzales also complained about a recent stiff neck episode. His pain levels were 6 to 7 for the knee and 7 to 8 for the low back.[13] The pain in the back was achy; the sensation in the knee was burning pain. Mr. Gonzales felt he was unable to continue with modified duty, operating the vibrating mowing machine

[13]The patient reference sheet that lists pain levels from 0 to 9 indicates pain level 6 is moderate to severe pain which requires time off of work. Level 8 pain is very severe pain that requires a person to stay in bed "most of the time," with associated inability to sleep, even with medication (EX 52).

A cervical CT scan indicated mild spurring at C3-4 and C4-5, with slight neural encroachment on the left. Spurring and disc bulging was also present at C6-7. The thoracic CT scan disclosed some narrowing at C7-T1. The lumbar CT scan showed a disc bulge at L2-3 and L3-4 with neural encroachment. Changes at L4-5 consistent with the prior surgery were present. An EMG indicated S1 radiculopathy. Physical examination revealed an antalgic gait. The back was tender midline from the cervical spine to the lumbar region, with paraspinal muscle tenderness in the lumbar area. Normal strength and muscle tone were noted for the back. The right lower extremity was normal. The left knee was tender at the joint line; he had full range of motion with pain.

Based on his evaluation, Dr. Hager diagnosed left knee derangement related to the June 1, 2001 accident; post traumatic and surgical arthritis from the June 1, 2001 accident; and aggravation of low back pain from the June 1, 2001 accident; acute lumbosacral radiculopathy due to the June 1, 2001 accident; and cervical-thoracic sprain due to the June 1, 2001 accident. Dr. Hager recommended electric muscle stimulation physical therapy and a referral to Dr. Terry Smith. He opined that Mr. Gonzales should retire with 100% disability due to his work-related injury on June 1, 2001.

After a September 19, 2002 examination, Dr. Hager concluded Mr. Gonzales should retire with 100% disability. He was not able to work a sedentary job because of severe back, neck and knee pain with intolerance to sitting and standing for long periods. Dr. Hager referred Mr. Gonzales to Dr. Terry Smith for a spinal surgery consultation evaluation.

On February 17, 2003, Mr. Gonzales complained that Dr. Ma had twisted his knee during an examination which increased swelling in his knee and caused a pain in his neck. He had retired with disability on November 25, 2002. No other change in his symptoms was reported. Left knee was 7 and back pain ran as high as 8. He continued to take only over-the-counter pain medication. According to Dr. Hager, Mr. Gonzales remained 100% disabled due to his June 1, 2001 injury.

On March 17, 2003, Mr. Gonzales reported that a few days earlier he felt the knee lock, pop, and then give way. During his fall, he hit his right knee, elbow and the right side of his head. Pain levels and other symptoms were unchanged.

Personnel Notes
(CX 5 and EX 38)

On July 25, 2002, Dr. Hager informed the Employer that Mr. Gonzales would be off work for four weeks. He recommended retirement with disability. The date of injury was listed as June 1, 2001.

On August 9, 2002, Dr. Hager added another four weeks off duty. He diagnosed lumbosacral disease, left knee derangement, and cervicalthoracic sprain. Dr. Hager recommended continued follow-up visits and a referral to Dr. Terry Smith for a back surgery consult.

Physical Therapy Treatment Notes
(CX 1)

Based on a referral from Dr. Hager, Mr. Gonzales received physical therapy for his back from November 26, 2002 through December 11, 2002. Mr. Gonzales reported muscle spasms in his back running down to his left leg. He also experienced left leg cramping. On December 11, 2002, after a treatment session, which included traction, Mr. Gonzales reported pain in his left lower back and right neck area.

Hearing Testimony
(TR, pages 181 to 216)

Dr. Hager, board certified in physical medicine and rehabilitation medicine,[14] first saw Mr. Gonzales on May 3, 2002 for spinal complaints. He presented complaints of neck, upper back, mid back, and low back pain.

Mr. Gonzales' medical history included a low back injury in 1968 which was treated with spinal fusion surgery in 1969. Afterwards, for several years, he did not experience any problems with his back. He started working for Marine Corps MWR in 1987. Subsequently, he suffered a slip and twist injury to his left knee. The incident also aggravated his back and his pain symptoms returned, along with pain in the upper back and neck. Dr. Hager's record is not clear whether the back problems started right after the knee injury.

Dr. Rasmussen, an orthopedic surgeon, treated Mr. Gonzales' left knee injury. She performed an arthroscopic repair. After the surgery, Mr. Gonzales returned to work on restricted duty in August 2001. However, he continued to have problems with his left knee.

Mr. Gonzales had experienced back and neck problems after the knee injury. His knee problem became more significant when he had to operate a mower that did not have an adequate suspension system. The jostling and vibration from the machinery increased his knee pain, that led to increased limping, which in turn aggravated his back and neck. Dr. Hager agrees with Mr. Gonzales' causation reasoning. Clearly, the jostling will aggravate any pre-existing back problems. Additionally, the awkward seating positions on the equipment would aggravate the knee pain and increase his limping. Because Mr. Gonzales did have back problems earlier on this machinery, Dr. Hager believes the knee injury-induced limp became an important factor in the development of the back pain.

After his evaluation, Dr. Hager diagnosed post-traumatic and surgical arthritis in the left knee, aggravation of low back pain by the June 2001 accident, and continued exacerbation of his symptoms due to his job duties, which amounts to a cumulative injury. Additionally, Dr. Hager stated Mr. Gonzales' lumbosacral radiculopathy was related to the aggravated low back pain.

Dr. Hager was concerned because Mr. Gonzales was still working. Due to other health problems, Mr. Gonzales was at risk for a significant cardiac event. The physical stress associated with his limp and working with a painful condition could aggravate his high blood

[14]In the absence of an objection, I accepted Dr. Hager as an expert witness concerning rehabilitative medicine.

pressure and prove to be a risk to his general health. Continued working also risked further cumulative damage to his knee and spine.

Dr. Hager found no reason to doubt the credibility of Mr. Gonzales' pain presentation. Objective findings validated his knee complaints.

Dr. Hager knew Dr. Rasmussen was treating Mr. Gonzales for his knee. In order to get a better sense for the condition of Mr. Gonzales' spine, Dr. Hager ordered a CT scan study. The radiographic imaging showed mild osteophytic spurring at C3-4 and C5-6, disc bulge as C6-7 with some bilateral encroachment of the neural foraminal outlets. Dr. Hager does not believe the findings are normal arthritic changes due to aging. Instead, the findings represent significant changes. Dr. Hager indicates the machine jostling "would have contributed to these findings," accelerated and worsened the pre-existing spinal conditions, and made them symptomatic.

Upon physical examination, Dr. Hager also found "tenderness of the spine and tightness of the paraspinal muscles." Additionally, inflammation of the facet joints due to arthritis produced pain locally consistent with Mr. Gonzales' symptoms. These symptoms were also consistent with his work activities, in particular vehicles without adequate suspension.

Dr. Hager noted that when he first saw Mr. Gonzales, he did not have the numbness in his fingers. That symptom has developed since the first visit.

The CT scan also identified multiple problems in the lumbar spine, including disc bulges at L2-3 and L3-4 and significant disc space narrowing at L4-5 and L5-S1. Some of the findings were consistent with Mr. Gonzales' previous back surgery.

Dr. Hager's upper extremity electrodiagnostic study found "ongoing radiculopathy at C5 bilaterally," which is a direct result of the cervical spine pathology. This problem is also work-related. Mr. Gonzales also had some nerve entrapment in his wrist.

The best treatment for these problems was the termination of the activities that aggravated them, like vibrational machinery.

The lower extremity study produced abnormal findings consistent with mild motor radiculopathy at S-1 on the left.

Dr. Ma apparently did not review the electrical tests, which Dr. Hager believes are important. The studies confirmed Dr. Hager's belief that Mr. Gonzales had on-going radiculopathy of the cervical and lumbar spine.

Dr. Hager took Mr. Gonzales off work on July 25, 2002. He has continued to see Mr. Gonzales on a regular basis and managed his condition with medication. Mr. Gonzales prefers over-the-counter pain relief medicine.

Due to his findings, Dr. Hager referred Mr. Gonzales to Dr. Smith, an orthopedic surgeon who specializes in spinal treatments. After evaluating Mr. Gonzales in January 2003, Dr. Smith

suggested cervical epidural injections. If that treatment proved ineffective, he recommended consideration of surgical stabilization of C5-6 and C6. Dr. Hager is still waiting for Dr. Smith's recommendation about the lumbar spine.

So far, authorization for the injection treatments had not been given.

Dr. Hager diagnosed left knee derangement, significant cervical stenosis with cervical radiculopathy, bilateral carpel tunnel syndrome, and "cervical, thoracic, and lumbosacral disc disease aggravated by his work."

Mr. Gonzales has not reached maximum medical improvement because epidural injections are recommended to help him become more comfortable with his neck and back injuries, and associated numbness. In regards to the left knee, Mr. Gonzales' antalgic gait and range of motion problems are aggravating his low back pain.

[Cross examination] Dr. Hager makes his own interpretations of CT scans and MRIs. Dr. Hager has seen Mr. Gonzales more than twelve times. The exhibits EX 52, EX 54, and EX 55 are copies of his interim reports for May 2002, February 2003 and March 2003. He prepared these reports on a computer using a template. Based on the evaluation, he makes necessary changes. The documents themselves do not indicate when they were prepared; however he completed the reports on the day he saw Mr. Gonzales.

Dr. Hager does not recall how soon after he first evaluated Mr. Gonzales that he recommended a retirement disability. He probably made the recommendation within two months. Based on the CT scan findings, Dr. Hager was concerned Mr. Gonzales remained at risk performing his job; "he was at risk of worsening to the point of having serious problems with his cervical stenosis and radiculopathy problems."

Dr. Hager is not aware of whether the Employer offered to accommodate Mr. Gonzales with any restrictions. Dr. Hager did not impose any work restrictions prior to making the retirement disability recommendation.

Personnel Records

Employment Document
(EX 34)

On August 10, 1987, Marine Corps MWR hired Mr. Gonzales to work full-time as a laborer on the golf course.

Early Retirement Opportunity
(EX 27, EX 28, and EX 29)

On May 1, 1999, the Employer offered Mr. Gonzales the opportunity for an early retirement based on age and service criteria. The election of the early retirement was entirely

voluntary. On May 10, 1999, Mr. Gonzales expressed an interest in "learning more about my options."

Job Descriptions
(CX 6, CX 7, CX 16, EX 20, and EX 21)

An August 6, 2002 letter from the Employer's representative indicates the availability of a position for Mr. Gonzales which accommodates Dr. Rasmussen's permanent work restrictions of June 4, 2002. The position is a golf course checker, NF-01, at the hourly rate of $5.75 per hour.

An August 7, 2002 job description for Mr. Gonzales' work as a motor vehicle operator indicates light duty is available and that the golf course supervisor and superintendent will continue to follow Dr. Rasmussen's work restrictions (*see* CX 8). The machinery requires repetitive foot movement but does not require walking on uneven ground. Specifically, he will be assigned to either a Sand Pro to rake sand traps or the rough mower. The description indicates Mr. Gonzales will not have to climb up or down the Sand Pro until the entire job is completed. Likewise, the mower does not require frequent climbing. No lifting or carrying is required and only minimal walking, standing or climbing is necessary.

The job description of motor vehicle operator, NA-5, indicates the individual will operate various gas and diesel powered specialized equipment on the golf course. The work requires driving equipment on hills and rolling terrain. The physical labor is light to moderate and includes frequent handling of heavy objects and the occasional replacement of vehicle tires.

First Report of Injury
(EX 2)

On June 5, 2001, the Employer filed a First Report of Injury stating that in the early morning of June 1, 2001, Mr. Gonzales had injured his left knee and leg when his left foot slipped on the fender of a tee mower and twisted his left knee. He completed his shift at 12:30 p.m. and then reported the incident to his supervisor.

First Report of Injury
(EX 3)

On November 11, 2002, in response to a claim submitted by Mr. Gonzales on October 29, 2002, the Employer reported that he claimed to have suffered cumulative injuries to his shoulders, upper extremities, spine and lower extremities from wear and tear. The date of accident is listed as April 10, 2002.

Disability Compensation Claim
(EX 4)

On June 28, 2001, Mr. Gonzales filed a disability compensation claim for damage to his left knee ligament and leg that he suffered on June 1, 2001 while operating a tee mower. His usual workweek was five days a week.

Disability Compensation Claim
(EX 5)

On October 29, 2002, Mr. Gonzales filed a disability compensation claim for cumulative wear and tear to his shoulders, spine, and upper and lower extremities. As the date of injury, Mr. Gonzales indicated cumulative injury through April 10, 2002.

Disability Compensation Payments
(EX 6, EX 7, EX 11, EX 12, EX 13, EX 14, and EX 44)

Between June 5, 2001 and August 28, 2001, the Employer paid Mr. Gonzales temporary total disability compensation at the weekly compensation rate of $337.29, based on an average weekly wage of $505.94. The Employer indicated Mr. Gonzales had exercised his choice of physician in seeing Dr. Rasmussen for his knee injury. A document filed August 29, 2002 indicates Mr. Gonzales will not be at work from July 25, 2002 through November 25, 2002.

Using the same compensation rate, and based on Dr. Ma's assessment, on October 24, 2002, the Employer initiated payment of permanent partial disability compensation for a 20% loss of use of the left leg due to a June 1, 2001 injury. The total payment was $19,427.90 representing 57.6 weeks at $337.29 per week.

Controversion of Claim
(EX 9 and EX 10)

On August 5, 2002, the Employer controverted all medical treatment by Dr. Hager since he was not an authorized treating physician for the left knee injury of June 1, 2001. The Employer contested all temporary total disability payments after July 25, 2002 because the treating physician, Dr. Rasmussen, had previously approved Mr. Gonzales' return to work. On November 11, 2002, the Employer also controverted Mr. Gonzales' disability compensation claim based on an April 10, 2002 injury.

Light Duty Notice
(EX 16)

On August 2, 2001, an Employer's representative indicated that light or modified duty was available for Mr. Gonzales in his regular job position.

Performance Appraisal
(EX 18)

For the rating period March 2001 to March 2002, Mr. Gonzales received a rating of "satisfactory" in all performance categories. The rater, Mr. Cazinha, indicated that Mr. Gonzales had been injured at work and was under work restrictions (light duty).

E-mail Correspondence
(EX 22)

An October 24, 2002 e-mail correspondence between representatives of the Employer/Insurer indicates a decision to offer Mr. Gonzales the checker job at the golf course. A November 5, 2002 note indicates a determination that the checker job will meet the permanent physical restrictions established on June 4, 2002.

Position Offer
(EX 25)

On November 18, 2002, the Employer offered Mr. Gonzales the position of checker at the Marine base golf course. The position was full time, 40 hours a week, at $6 an hour. The offer was being made since Mr. Gonzales' doctor had indicated he was precluded from returning to his position as an NA-5 motor vehicle operator. Mr. Gonzales was advised that failure to accept the offer might affect his workers' compensation benefits. The letter also indicated his non-adverse, non-disciplinary separation from Marine Corps MWR would occur if he did not accept the offer. Spaces were provided for Mr. Gonzales to either accept or decline the offer.

Retirement Action
(EX 26, EX 31, and EX 32)

On November 25, 2002, Mr. Gonzales submitted his application to retire with disability, effective the same day. In an endorsement, the separations manager indicated Mr. Gonzales would not be rehired because he was not eligible for rehire in the current position due to his disability.

An accompanying note by an Employer/Insurer's representative states that Mr. Gonzales did not respond to the November 18, 2002 job offer; instead, he submitted his retirement application.

For a retirement date in September 2002, Mr. Gonzales' estimated monthly retirement benefit, without a survivor benefit annuity, was about $223.

Retirement Certificate of Appreciation
(CX 2)

Mr. Gonzales received a Certificate of Appreciation upon his retirement on December 1, 2002 for 15 years and 3 months of service.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact and Preliminary Findings

The parties have stipulated to the following facts: On June 1, 2001, Mr. Gonzales suffered an injury to his left knee during and in the course of his employment with the Employer. At that time, an employer-employee relationship existed between the parties. The applicable average weekly wage is $505.94. (TR, pages 9, 18, 19, 28, 29, and 139).

Issue No. 1 – Left Knee Injury Disability Compensation and Medical Benefits

A. Nature of Disability

Under the Act, a longshoreman's inability to work due to a work-related injury is addressed in terms of the nature of the disability (permanent or temporary) and extent of the disability (total or partial). In a claim for disability compensation, the claimant has the burden of proving, through the preponderance of the evidence, both the nature and extent of the disability. *Trask v. Lockheed Shipbuilding & Constr. Co*., 17 BRBS 56, 59 (1985).

The nature of a disability may be either temporary or permanent. Although the consequences of a work-related injury may require long term medical treatment, an injured employee reaches maximum medical improvement when his condition has stabilized. *Cherry v. Newport News Shipbuilding & Dry Dock Co*., 8 BRBS 857 (1978). In other words, the nature of the worker's injured condition becomes permanent and the worker has reached maximum medical improvement when the medical evidence establishes the individual has received the maximum benefit of medical treatment such that his condition will not improve. *Trask*, 17 BRBS at 60. At the same time, permanency does not mean unchanging. An impairment may be permanent even if there is a hypothetical possibility that the employee's condition may improve at some future date. *Watson v. Gulf Stevedore Corp.*, 400 F.2d 649, 654 (5th Cir. 1968) *cert. denied,* 394 U.S. 976 (1969). Any disability suffered by a claimant prior to MMI is considered temporary in nature. *Berkstresser v. Washington Metropolitan Area Transit Authority*, 16 BRBS 231 (1984). If a claimant has any residual disability after reaching MMI, then the nature of the disability is permanent.

As the parties stipulated, Mr. Gonzales suffered a work-related left knee injury on June 1, 2001. The Claimant asserts the nature of the associated disability is temporary. The Employer maintains Mr. Gonzales has suffered a permanent impairment to his left knee. To resolve this dispute, I must evaluate the diverse opinion presented by three physicians on whether Mr. Gonzales' left knee has reached maximum medical improvement.

Dr. Rasmussen, the treating orthopedic surgeon, initially estimated that the condition of Mr. Gonzales' knee would improve with post-surgery physical therapy to the extent that he could return to work in late August 2001 in light duty and then assume full duties in October 2001. As Dr. Rasmussen predicted, Mr. Gonzales completed physical therapy and based on an August 23, 2001 examination, she indicated he could start working with temporary physical restriction on

August 29, 2001. At that time, Dr. Rasmussen opined Mr. Gonzales would reach maximum medical improvement on September 17, 2001.

However, when Dr. Rasmussen examined Mr. Gonzales on September 19, 2001, he continued to have knee problems associated with his use of the golf course equipment. As a result, Dr. Rasmussen prescribed additional exercises, moved the date of his return to full duty to the end of October 2001 and changed the MMI date to December 1, 2001.

When Mr. Gonzales returned in mid-November 2001, Dr. Rasmussen identified a persistent problem of knee cap pain; she administered a cortisone injection in an attempt to diminish the swelling and pain. In January 2002, Mr. Gonzales reported only temporary relief from the injections. At that time, Dr. Rasmussen found most of the knee to be stable with the exception of the knee cap pain. The physician believed additional quad muscle strengthening might help this problem so she prescribed additional physical therapy. This additional physical therapy continued through April 9, 2002 and Mr. Gonzales remained on light duty. In April 2002, Mr. Gonzales' knee cap pain continued and mild swelling returned to his left knee. In response, Dr. Rasmussen administered another injection, prescribed additional physical therapy and approved STS treatment.

On June 6, 2002, Dr. Rasmussen noted the knee swelling had somewhat resolved but the patellofemoral pain persisted. She recommended a knee injection, which Mr. Gonzales declined, anti-inflammatory medication, and quad muscle exercises. Notably, on this same day, Dr. Rasmussen concluded Mr. Gonzales' light duty work restrictions would remain permanent. Finally, when Mr. Gonzales returned in August 2002 and January 2003, Dr. Ramussen found essentially that same conditions and recommended injections, medication and exercise.

Due to the nature and sequence of Dr. Rasmussen's notes, and in the absence of a deposition, I must determine her opinion on MMI through inference based on circumstantial evidence and her treatment of Mr. Gonzales' injured left knee. First, I discard her initial estimation of September 17, 2001 as the date of maximum medical improvement. Two days after September 17, 2001, Dr. Rasmussen specifically changed the MMI date to December 1, 2001.[15] Second, based on her administration of new treatments in 2002, such as injections and STS therapy, I conclude Dr. Rasmussen's MMI date of December 1, 2001 also misses the mark. In April 2002, Dr. Rasmussen opined that unless the inflammation in Mr. Gonzales' left knee was brought under control, he would not be able to return to his regular duties at the golf course. Next, by June 6, 2002, Dr. Rasmussen had exhausted her arsenal of potential therapies to improve Mr. Gonzales' left knee condition. Despite physical therapy, STS treatments, and cortisone injections, Mr. Gonzales' painful left knee did not improve. Consequently, on June 6, 2002, Dr. Rasmussen concluded Mr. Gonzales' work restrictions due to the condition of his left knee would become permanent.

Setting permanent work restrictions does not necessarily mean an employee has reached MMI. Yet, in this particular case, over several months of treatment, Dr. Rasmussen fundamentally changed her position on the possibility of resolving Mr. Gonzales' left knee pain.

[15]Although in June 2002, Dr. Rasmussen's again referred to September 17, 2001 as the date of MMI, that reference is clearly an error.

Initially, the physician believed Mr. Gonzales would return to full duty after some healing and physical therapy by late summer of 2001. She continued to believe resolution was possible into the late fall by moving the estimated MMI date to December 1, 2001. However, in June 2002, after additional treatment modalities in the spring of 2002 provided only temporary relief, Dr. Rasmussen established permanent work restrictions based on the persistent painful condition of Mr. Gonzales' left knee. This determination signaled her new belief that continued medical treatments would not improve the condition of his left knee and at best would only keep his symptoms in check. By June 2002, Dr. Rasmussen clearly saw no potential for improvement of Mr. Gonzales' left knee pain and thus rendered his physical work restrictions permanent. Under these circumstances, I conclude Dr. Rasmussen's permanent work restriction determination indicates her belief that Mr. Gonzales reached maximum medical improvement on June 6, 2002.

Dr. Ma, an orthopedic surgeon, evaluated Mr. Gonzales' left knee in July 2002 and found limited range of motion. Following his examination, he opined that Mr. Gonzales may not have reached maximum medical improvement and recommended an additional arthroscopic evaluation by a sports medicine specialist to determine whether any additional improvement was possible. Absent such a referral, Dr. Ma found Mr. Gonzales suffered a 20% permanent impairment to his left lower extremity.

During the hearing, Dr. Ma again stated he really didn't know whether Mr. Gonzales' left knee had reached MMI. He explained that his recommendation for an additional evaluation represented a suggestion to Dr. Ramussen that she might consider an additional referral. Dr. Ma left the referral decision to Dr. Ramussen. He also stated his belief that the further evaluation only represented the possibility, rather than the probability, of improvement in the left knee flexion limitations. Moreover, he noted the degenerative arthritic condition of the left knee and damage to the medial femoral condyle, which has been partially accelerated by Mr. Gonzales' heavy duty work, is irreversible.

Dr. Hager, a rehabilitative medicine specialist, evaluated Mr. Gonzales' back and neck complaints in mid-2002. As part of that process, he diagnosed post-traumatic and surgical arthritis, with continued job induced aggravation, in the left knee. In regards to the neck and back, Dr. Hager concluded Mr. Gonzales had not reached MMI because epidural injections might provide some improvement in his condition.

In evaluating the three medical opinions on the issue of MMI, Dr. Hager's assessment is the least probative. Due to the nature of his treatment of Mr. Gonzales, he rendered an MMI determination only in terms of the back and neck. He did not make a specific MMI finding for the left knee.

Initially, based on their medical reports, the remaining two physicians seem to disagree. Dr. Ma did not find MMI. In contrast, Dr. Rasmussen appears to have concluded Mr. Gonzales' left knee sufficiently is medically stable to warrant imposing permanent work restrictions. In assessing the relative probative value of these two assessments, Dr. Ma's assessment has slightly less probative value because he equivocates on the issue. Essentially, Dr. Ma was not completely certain about MMI; yet further medical improvement is only a possibility. Specifically, Dr. Ma does not believe additional improvement in the knee's range of motion is

probable. In contrast, Dr. Rasmussen's treatment notes demonstrate a deliberative transition in her prognosis to the final conclusion that Mr. Gonzales' left knee has medically stabilized to the point that no further improvement is expected and permanent work restrictions are warranted. Additionally, as the treating orthopedic surgeon, Dr. Rasmussen was in the best position to fully appreciate and understand the potential for any further medical improvement in Mr. Gonzales' left knee.

Accordingly, based on Dr. Rasmussen's probative medical findings and conclusions, I find that Mr. Gonzales' injured left knee reached maximum medical improvement on June 6, 2002. On that date, the nature of his lower extremity impairment due to his June 1, 2001 left knee injury changed from temporary to permanent.

B. Disability Compensation

Since Mr. Gonzales has suffered a permanent injury to a limb that is listed in the Section 8 schedule for permanent partial disability, he is automatically entitled to a certain level of compensation as a result of his injury and no proof of actual wage-earning capacity is required to receive the specified compensation. *See Travelers Insurance Co. v. Cardillo,* 225 F.2d 137 (2d Cir.), *cert. denied,* 350 U.S. 913 (1955).

The method and amount of the actual compensation for a permanent partial disability is established by Section 8 (c) of the Act, 33 U.S.C. § 908 (c). The adjudication of a permanent partial disability under the schedule is based solely on physical factors. *Bachich v. Seatrain Terminals*, 9 BRBS 184, 187 (1978). In the first portion of this section, Sections 8 (c) (1) to (c) (17), compensation for numerous types of injuries, such as loss of a leg, is established by a specific schedule of awards. Although the first 17 subparagraphs address the total loss of a specified limb, an eye or hearing, Section 8 (c) (19) provides that partial loss of use of a limb is compensated as a proportional loss of use of the limb. The Benefits Review Board and the courts apply the proportionality principle set out by Section 8 (c) (19) for a partial loss of use by indicating the compensation runs for the proportionate number of weeks attributable to the loss of the member at the full compensation rate of two-thirds of the average weekly wage. *Nash v. Strachan Shipping Co.*, 15 BRBS 386 (1983), *aff'd in relevant part but rev'd on other grounds*, 760 F.2d 569 (5th Cir. 1985), *aff'd on recon en banc,* 782 F. 2d 513 (1986). The date of permanency establishes a claimant's date of entitlement to the scheduled award. *Turner v. Bethlehem Steel Corp.,* 17 BRBS 232, 235 (1985).

In determining the appropriate degree (or proportionate) loss of use in a permanent disability compensation case, the Benefits Review Board in *Peterson v. Washington Metro. Area Transit Auth*., 13 BRBS 891, 897 (1981), stated an administrative law judge "is not bound by any particular formula when determining the degree of permanent partial disability and that it is within his discretion to assess a degree of disability different from the ratings found by the physicians if that degree is reasonable." Finally, a knee injury is adjudicated under Sections 8 (c) (2) and (c) (19) of the Act as partial loss of use of the leg. *Nash,* 15 BRBS at 391.

Although Dr. Rasmussen found Mr. Gonzales' left knee condition sufficiently stable to change his temporary work restrictions to permanent limitations, she did not make a permanent

impairment rating. The only doctor to address the specific extent of Mr. Gonzales' left knee limitations was Dr. Ma. According to Dr. Ma, if Mr. Gonzales did not pursue any additional surgery, the condition of his left knee represented a 20 % loss of use of the left lower extremity due to an impaired range of motion. Dr. Ma's permanent disability rating has probative value because he rendered the impairment determination within a month of Dr. Rasmussen's probative finding of permanency on June 6, 2002. Based on Dr. Ma's un-rebutted opinion, I find Mr. Gonzales has suffered a permanent 20% impairment to his left lower extremity due to his June 1, 2001 left knee injury. Accordingly, Mr. Gonzales is entitled to a proportional award of permanent partial disability compensation under Section 8 (c) (2) and (19) for partial loss of use of his left leg, based on an average weekly wage of $505.94. The effective date of this entitlement is June 6, 2002, when Dr. Rasmussen essentially determined the nature of his left knee condition became permanent.

At the hearing, Mr. Birnbaum asserted that an assessment of additional compensation in the form of a penalty would be appropriate if Mr. Gonzales was found to have a ratable permanent impairment.

Section 14 (e) imposes a 10% penalty on an overdue payment payable without an award if the payment is not made within 14 days after it becomes due. Additionally, Section 14 (e) suspends any penalties if a timely controversion has been filed under Section 14 (d). Such controversion is timely if an Employer submits the controversion within 14 days after it has knowledge of the alleged injury. Based on this language, the starting point for liability is 28 days[16] after the employer is aware of the injury. *DeRoberts v. Oceanic Container Service*, 14 BRBS 284 (1981). The duration of liability under Section 14 (e) ceases on the date of the filing of the notice of controversion. *National Steel & Shipbuilding Co. v. U.S. Dep't of Labor*, 606 F.2d 875 (9th Cir. 1979) *aff'g in part and rev'g in part Holston v. National Steel & Shipbuilding Co.*, 5 BRBS 794 (1977). In Section 8 (c) scheduled injury cases, where a claimant loses no time from work or has returned to work and the parties wait in good faith to determine the permanency or extent of partial impairment under the schedule, an employer has 14 days after receiving knowledge of the permanency of the claimant's condition and/or the extent of his impairment to controvert liability for the scheduled injury. In the absence of a timely controversion, liability for additional compensation occurs fourteen days after the close of the fourteen day controversion filing period. *DeRoberts*, 14 BRBS at 289.

Following his left knee surgery and physical therapy, Mr. Gonzales returned to work in light duty status and continued that employment through July 25, 2002. At the beginning of June 2002, Dr. Rasmussen informed the Employer of the permanency of Mr. Gonzales' work restriction and by July 12, 2002, Dr. Ma had rated the permanent impairment to the left knee. Based on these circumstances, I conclude that the Employer was aware of the permanency and rating of Mr. Gonzales' left knee impairment as of July 12, 2002. Thus, under the time thresholds discussed above, twenty-eight days after July 12, 2002, which is August 8, 2002, the Employer became liable for the initiation of permanent partial disability compensation. The Employer did not initiate its payment of permanent partial disability benefits until October 24, 2002. Consequently, Mr. Gonzales is entitled to additional compensation for the overdue

[16]After the fourteen days provided to the Employer to controvert an injury, the disability payment becomes due. Another fourteen days later, the payment is overdue and penalties are initiated.

disability compensation payment during the period from August 8, 2002 through October 23, 2002.

C. Change of Physician

As part of his entitlement under Section 7 of the Act, Mr. Gonzales seeks to change his choice of physician for his left knee injury due to the poor result arising out of Dr. Rasmussen's treatment of his left knee.

Section 7 (c) (2) of the Act, 33 U.S.C. § 907 (c) (2), and 20 C.F.R. § 702.406 provides that an employer must authorize medical treatment by the physician chosen by the employee. However, unless the chosen doctor was not an appropriate specialist for the injury, once a claimant has made his initial free choice, he may not change physicians without the prior written consent of the employer, carrier or deputy commissioner. In this situation, consent may be given upon a showing of good cause. On the other hand, if the employer has effectively refused to provide medical treatment, a claimant does not have to obtain prior approval for a change of physician. *See Slattery Assocs. v. Lloyd,* 725 F.2d 780, 787 (D.C. Cir. 1984).

Based on these statutory and regulatory provisions, in evaluating a change of physician request, I must determine whether: a) the claimant made an initial free choice of physician; b) the chosen physician provided necessary specialized care; c) the employer has refused further medical treatment; and, d) good cause exists for a change.

With these considerations in mind, I turn to the specifics of Mr. Gonzales' case. After his knee injury, Mr. Gonzales went to his personal physician, Dr. Lum. Then, when he followed Dr. Lum's specialist referral, Mr. Gonzales exercised his free choice of physician by seeing Dr. Rasmussen for treatment of his injured left knee. Dr. Rasmussen, a board certified orthopedic surgeon, possessed the requisite specialized medical skills for the treatment of his damaged left knee. The record contains no evidence that the Employer has refused to provide any further medical treatment by Dr. Rasmussen. Since Mr. Gonzales exercised his free choice of a medical specialist and the Employer has not refused continued care by that physician, my inquiry focuses on whether good cause exists for permitting a change of physicians.

Initially, Dr. Ma's presentation seems to indicate that good cause may exist for a change of physician because Mr. Gonzales had experienced a bad result from Dr. Rasmussen's treatment. However, Dr. Ma later clarified his statement by indicating that Mr. Gonzales had a poor outcome from his left knee surgery due to the pre-existing condition of the left knee. Dr. Ma, also an orthopedic surgeon, believed Dr. Rasmussen had rendered appropriate medical care for the left medial meniscus tear. Thus, no medical opinion exists to support a determination that the medical specialist Mr. Gonzales chose is not providing appropriate medical care for his left knee. Significantly, I also note that despite his counsel's contrary representation, Mr. Gonzales testified that he did not go to Dr. Hager because he was unhappy with Dr. Rasmussen's care. In fact, he still continues to see Dr. Rasmussen for treatment of his left knee. Accordingly, good cause does not exist to warrant a change of physician in regards to treatment of Mr. Gonzales' impaired left knee.

Issue No. 2 – Cumulative Injury/Aggravation of Pre-existing Condition
Disability Compensation and Medical Benefits

On October 29, 2002, Mr. Gonzales filed a claim for disability compensation and medical benefits associated with "cumulative wear & tear" to his shoulders, upper extremities, spine, and lower extremities (EX 5). He alleged the "CT" (cumulative trauma) occurred through April 10, 2002. The Employer contests Mr. Gonzales' cumulative injury claim.

A. Timely Notice

As an initial defense to Mr. Gonzales' cumulative injury claim, the Employer asserts that he failed to file a timely notice of injury. The late notice prejudiced the Employer's ability to investigate the circumstance of the claimed cumulative injuries.

Principles

The first step in evaluating whether timely notice of a cumulative injury has occurred requires understanding the various definitions of "injury" under the Act. Section 2 (2) of the Act, 33 U.S.C. § 902 (2), defines a compensable injury as an accidental injury arising out of and in the course of employment. The term, "injury" is considered to encompass both physical harm and conditions which indicate something had gone wrong within the human frame. *Wheatley v. Adler,* 407 F.2d 307 (D.C. Cir. 1968). If something unexpectedly goes wrong within the human frame, whether by lesion or change in any part of the system, which produces harm, pain, or lessened facility of natural use, even if it occurs in the course of usual and ordinary work, a claimant has sustained an accidental injury. *McGuigan v. Washington Metropolitan Area Transit,* 10 BRBS 261, 263 (1979) and *Gardner v. Bath Iron Works Corp.,* 11 BRBS 556, 558 (1979), *aff'd sub. nom, Gardner v. Director, OWCP,* 640 F.2d 1385 (1st Cir. 1981).

If an initial medical condition progresses into complications more serious than the original injury, the additional complications represent compensable injuries. *Andras v. Donovan,* 414 F.2d 241 (5th Cir. 1969). An injury may develop over a period of employment and still be considered accidental. *Gencarelle v. General Dynamics Corp*., 22 BRBS 170 (1989), *aff'd*892 F.2d 173 (2d Cir. 1989) (synovitis of the knee, an arthritic condition aggravated by repeated bending, stooping, and climbing on the job, may be considered an accidental injury rather than an occupational disease). According to the Benefits Review Board ("Board" or "BRB"), credible complaints of subjective symptoms and pain may be sufficient to establish an injury and an inability to work under the Act. *See Sylvester v. Bethlemhem Steel Corp.*, 14 BRBS 234, 236 (1981), *aff'd sub nom., Sylvester v. Director,* OWCP, 681 F.2d 359 (5th Cir. 1982) and *Anderson v. Todd Shipyards Corp*., 22 BRBS 20 (1989). Finally, a claimant suffers an injury if his employment aggravates a non-work-related, underlying disease or condition to the extent the claimant suffers incapacitating symptoms. *Preziosi v. Controlled Indus.*, 22 BRBS 468 (1989).

Next, recognizing that injuries under the Act include both traumatic accident-induced damage and cumulative physical harm, Section 12 (a) of the Act, 33 U.S.C. § 912 (a), requires that a claimant provide notice of a work-related injury within 30 days of either a) the date of

injury, or b) within thirty days[17] after a claimant becomes reasonably aware, or should have become aware, of the relationship between the disability and employment. Failure to provide such notice of injury will bar a claim for disability compensation under the Act unless the employer was actually aware of the injury or fails to establish that it was prejudiced by the lack of notice. Section 12 (d). "To establish prejudice, the employer bears the burden of proving by substantial evidence that it has been unable to effectively investigate some aspect of the claim due to the claimant's failure to provide timely notice pursuant to Section 12." *Steed v. Container Stevedoring Co.* 25 BRBS 210, 216 (1991).

The first portion of Section 12 (a) relates to an injury caused by a traumatic accident at work. Under that provision, the date of the work-related accident sets the date of the injury for purposes of the Section 12 (a) 30 day notice requirement. The second part of Section 12 (a) covers injuries alleged to have developed over the course of employment due to cumulated physical stress. In that situation, the appropriate associated date of injury occurs when the long term damage becomes manifest and the claimant reasonably becomes aware of the relationship between the bodily harm and his employment. *See Travelers Insurance Co. v. Cardillo,* 225 F.2d 137 (2d Cir.), *cert. denied,* 350 U.S. 913 (1955) and *Thorud v. Brady-Hamilton Stevedore Co., et. al.,* 18 BRBS 232 (1987). Notably, when one injury arises out of an accident that has been reported, a claimant does not have to give a separate notice of other injuries resulting from the same incident. *Thompson v. Lockheed Shipbuilding & Constr. Co.,* 21 BRBS 94 (1988).

Discussion

In the spring of 2002, coinciding with his re-assignment exclusively to NA-5 power equipment, Mr. Gonzales began to experience troubles with his spine, including his cervical spine, in addition to renewed left knee pain. On May 2, 2002, he presented to Dr. Hager pain complaints in all these areas. Since none of the physicians have expressed any doubts about the credibility of his pain complaints and some of the reported symptoms are consistent with objective medical evidence, I conclude Mr. Gonzales' credible complaints of pain in May 2002 establish that something had gone wrong in his back. That is, by the time Mr. Gonzales saw Dr. Hager, he had suffered some harm or injury to his back. Dr. Ma essentially concurred. Although Mr. Gonzales did not suffer a specific traumatic injury, Dr. Ma opined that the designated date of April 10, 2002 corresponded to an injury in the form of at least a temporary aggravation of a pre-existing back condition.

In the absence of any reported accident, Mr. Gonzales' credible complaints of back and neck pain, as corroborated by the medical opinions of Dr. Hager and Dr. Ma, establish the existence of a non-traumatic injury in the spring of 2002. Correspondingly, his October 2002 compensation claim with its incident date of April 2002 demonstrates Mr. Gonzales' belief that a

[17]For an occupational disease, the requisite notice period is one year. Mr. Gonzales is not claiming an occupational disease and his claimed injuries do not seem to fall within the category of occupational disease. *See Steed v. Container Stevedoring Co.* 25 BRBS 210, 214-16 (1991) (gradual work-related worsening of lumbar stenosis should be considered an accidental injury rather than an occupational disease because the employee's activities were not singular or peculiar to his employment).

connection existed at that time between his developing back and neck problems in spring of 2002 and the cumulative effects of his work.

Having concluded the claim form shows Mr. Gonzales' awareness of cumulative injuries to his back and neck by April 2002, I next consider when he first informed the Employer of these alleged cumulative injuries. During the spring of 2002, Mr. Gonzales presented some pain complaints to his supervisors at least a couple of times. However, his principal concern was his continued left knee pain and related back stress rather than increasing back and neck pain as cumulative injuries. As a result, I believe his statements to the golf course management were insufficient to establish notice that he was suffering cumulative injuries to his back and neck.

Mr. Gonzales also did not provide notice of cumulative injuries through Dr. Hager's medical reports. In his first contact with the Employer on July 25, 2002, Dr. Hager only indicated Mr. Gonzales had to miss work for four weeks and recommended a disability retirement. The doctor did not provide a diagnosis. When Dr. Hager subsequently furnished his detailed August 8, 2002 medical report, he still did not specifically reference any cumulative injuries. Instead, he presented Mr. Gonzales' back and neck problems as aggravation injuries related to the June 1, 2001 left knee injury. Consequently, Mr. Gonzales' October 29, 2002 cumulative injury compensation claim essentially presents the first notice to the Employer of his assertion that he has suffered cumulative injuries to his back and neck. That notice occurred several months after April 2002 when Mr. Gonzales should have reasonably become aware of the connection between his back and neck pain and prolonged use of the golf course equipment. Accordingly, his notice of alleged cumulative injuries due to his employment is untimely.

Turning to the requisite consideration under Section 12 (d) of actual prejudice to the Employer due to the late notice of injury, I conclude that Marine Corps MWR has failed to provided substantial evidence of such prejudice. While claiming the delayed notice prejudiced its investigation of the cumulative injuries, the Employer has failed to identify any specific prejudice. The delay of five months did not deny the Employer access to Mr. Gonzales, Mr. Mirata, the respective golf course power equipment, or Dr. Hager's earlier medical reports. Additionally, Dr Ma apparently had no difficulty during the January 2003 examination assessing the relationship between Mr. Gonzales' golf course work and his claimed cumulative injuries.

In summary, although Mr. Gonzales failed to file a timely notice of his alleged cumulative injuries under Section 12 (a), Marine Corps MWR has failed to establish the requisite Section 12 (d) prejudice due to the untimely notice. Accordingly, Mr. Gonzales' claim for cumulative injuries is not barred due to untimely notice.

B. Injury

Having determined Mr. Gonzales' cumulative injury claim is not dismissed due to timeliness, I must resolve the medical dispute between Dr. Hager and Dr. Ma to determine the specific nature of the claimed cumulative injuries, considering the Employer's contention that Mr. Gonzales did not suffer any cumulative injuries.

Initially, after the May 2002 examination, Dr. Hager diagnosed aggravation of the low back and strain of the cervical-thoracic spine due to the left knee accident of June 1, 2001. After reviewing spinal CT scans and an EMG study, Dr. Hager continued to reach the same diagnosis in his treatment notes through August 2002. However, at the May 2003 hearing, Dr. Hager stated that the aggravation of Mr. Gonzales' back represented a work-related cumulative injury. He added that Mr. Gonzales' radiculopathy was in turn related to the aggravated low back condition. Dr. Hager explained that the machinery vibration at work, in the absence of sufficient suspension, contributed to the painful condition of Mr. Gonzales' back by accelerating and worsening his pre-existing arthritic spinal condition. This explanation falls within the meaning of cumulative injury.

Based on his physical examinations and evaluation of the radiographic evidence, Dr. Ma believed Mr. Gonzales' operation of the golf course power equipment in the spring of 2002 simply aggravated his left knee problem, which in turn temporarily aggravated his pre-existing low back problems, producing low back pain. The April 10, 2002 incident date simply represents a minor and temporary aggravation of Mr. Gonzales' pre-existing, long standing degenerative disc condition. Mr. Gonzales did not sustain a very serious injury to his spine in April 2002 because the CT scan did not show any damage to his spinal cord.

In evaluating this conflict in medical opinion, I first assess the probative value of the medical opinions in terms of documentation and reasoning. A physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

On the issue of whether Mr. Gonzales' back and neck symptoms represent a separate cumulative injury or a simple aggravation of a pre-existing back condition, I am slightly troubled by the seeming sudden and delayed addition of a cumulative injury diagnosis by Dr. Hager. Prior to the hearing, Dr. Hager's medical reports only contained a diagnosis of an aggravated pre-existing back condition due to the left knee injury of June 1, 2001. Dr. Hager did not mention any diagnosis of cumulative injury in either his May 2002 initial evaluation or his August 22, 2002 medical report, which included his evaluation of the CT scans. In fact, his pre-hearing conclusions about the nature of Mr. Gonzales' back injury matched Dr. Ma's assessment. Subsequently, at the hearing, Dr. Hager added a major diagnosis of cumulative injury to Mr. Gonzales' spine from vibrating golf course equipment.

Setting aside my concern about Dr. Hager's delayed diagnosis, the critical probative distinction between the conflicting medical opinions rests on the accuracy of the physicians' respective underlying documentation, in particular, their individual interpretations of the spinal CT scans from the spring of 2002.[18] When Dr. Ma evaluated the CT scans, he found evidence of Mr. Gonzales' lower back surgery, an old pre-existing degenerated disc herniation at C6-7, and

[18]Notably absent in the record is the radiologist's interpretation of these CT scans.

some arthritic spurring. Otherwise the spine was normal for Mr. Gonzales' age. When studying the same radiographic films, Dr. Hager likewise observed the old surgical site L4-5 and the disc bulge at C6-7. However, he also stated the films showed "mild" spurring at C3-4 and C4-5 with "slight" neural encroachment, plus disc narrowing at C7-T1, a disc bulge at L2-3 and neural encroachment at L3-4. Dr. Hager characterized these additional findings as significant and indicated they were consistent with Mr. Gonzales' symptoms.

Although Dr. Hager was the treating physician for Mr. Gonzales' back and neck pain, I consider Dr. Ma, as an orthopedic surgeon, to be better qualified to interpret the skeletal images of Mr. Gonzales' spine than Dr. Hager who is board certified in rehabilitation medicine. I have noted Dr. Hager's observation that he evaluated the EMG study and Dr. Ma apparently did not. However, while that medical test showed radiculopathy at S1, Dr. Hager did not observe a defect in S1 in his CT scan evaluation. As a result, the EMG finding does not necessarily enhance the accuracy of his radiographic interpretation. I also recognize that Dr. Hager implied Dr. Smith, another orthopedic surgeon, agreed with his assessment by prescribing cervical epidural injections. Yet, the only information in the record about Dr. Smith's finding comes from Dr. Hager. The record does not contain either Dr. Smith's examination and objective medical test findings or his specific diagnosis.

When Dr. Ma applied his orthopedic expertise to the evaluation of the CT scans, he did not observe the extensive problems reported by Dr. Hager. Other than the lumbar surgical site, an old pre-existing disc herniation, and some arthritic spurring, Dr. Ma found essentially a normal spine. In light of his better credentials, Dr. Ma's interpretation is more accurate and enhances the probative value of his diagnosis. Based on Dr. Ma's more probative assessment, I conclude that in the spring of 2002, Mr. Gonzales suffered an aggravation of pre-existing conditions in his spine as a consequence of the earlier left knee injury, rather than a cumulative injury to his back.

At this point, although not really an issue, prior to addressing the nature and extent of disability associated with the aggravation of Mr. Gonzales' pre-existing back condition, I must nevertheless establish the etiology of the aggravation.

Absent substantial evidence to the contrary, Section 20 (a) of the Act. 33 U.S.C. § 920 (a), establishes a presumption that a disabling condition is causally related to employment if: a) the claimant suffered a harm; and, b) employment conditions existed or a work accident occurred which could have caused, aggravated, or accelerated the harm or condition. *Gencarelle v. General Dynamics Corp.* 22 BRBS 170 (1989), *aff'd* 892 F.2d 173 (2 Cir. 1989). In other words, the Act establishes a causation presumption that such an injury is work-related.

To rebut the Section 20 (a) causation presumption, the employer must present specific medical evidence proving the absence of, or severing, the connection between the bodily harm and the employee's working condition. *Parsons Corp. v. Director, OWCP (Gunter)*, 619 F.2d 38 (9th Cir. 1980). According to appellate court in the Ninth Circuit, the employer need only introduce medical testimony controverting causation, and does not have to prove another causation agent, to rebut the presumption. *Stevens v. Todd Pacific Shipyards*, 14 BRBS 626 (1982) *aff'd mem.* 722 F.2d 747 (9th Cir. 1983), *cert. denied* 467 U.S. 1243 (1984).

Once the Section 20 (a) presumption is rebutted, it no longer controls the adjudication. *Swinton v. J. Frank Kelly, Inc*. 554 F.2d 1075 (D.C. Cir.) *cert. denied* 429 U.S. 820 (1976). Instead, all the evidence in the record must be evaluated and the causation issue is then determined based on the preponderance of the evidence. *Noble Drilling Co. v. Drake*, 795 F.2d 478 (5th Cir. 1986).

Finally, if a claimant establishes the existence of a compensable injury, then the employer remains responsible for all natural consequences of that injury, whether they occur at work or outside, through the causation presumption under Section 20 (a). *Bludworth Shipyards v. Lira,* 700 F.2d 1046 (5th Cir. 1983) and *Kooley v. Marine Industries N.W.,* 22 BRBS 142 (1989). As a result, when an employee sustains an injury at work which is followed by the occurrence of a subsequent injury or aggravation, the employer is liable for the entire disability and the medical expenses due to both injuries if the subsequent injury or aggravation is the natural and unavoidable result or consequence of the original work-related injury.[19] *Bludworth,* 700 F.2d at 1050. If an initial injury produces a subsequent dysfunction in another body part, the later condition may be considered to be a natural and unavoidable consequence of the initial injury such that the later injury also becomes work-related. *See Uglesich v. Stevedoring Servs. of America,* 24 BRBS 180 (1981).[20] Likewise, if a claimant's employment aggravates a non-work-related, underlying disease or condition so as to produce incapacitating symptoms, the resulting disability may be compensable. *See Gardner v. Bath Iron Works*, 11 BRBS 556 (1979), *aff'd sub nom. Gardner v. Director, OWCP*, 640 F.2d 1385 (1st Cir. 1981).

In Mr. Gonzales' case, the medical opinions of Dr. Ma and Dr. Hager, coupled with his credible complaints of back pain, establish that he suffered some harm to his back in the spring of 2002. And, since the nature of his work as a machine operator with continued left knee problems and an associated altered gait could have caused that harm, Mr. Gonzales is able to invoke the Section 20 (a) presumption that his back and neck problems were related to his employment with the Marine Corps MWR as a machine operator.

No contrary medical opinion in the record rebuts this Section 20 (a) causation presumption. Further, as set out below, the medical evidence clearly ties Mr. Gonzales' back problems to his June 1, 2001 left knee injury. As a result, Mr. Gonzales' developing back pain in April 2002 represents a compensable injury.

In late 1969, Mr. Gonzales suffered a low back injury and eventually underwent a spinal fusion operation. Over the next 20 plus years, Mr. Gonzales experienced only occasional low back pain. In 1986, a spinal x-ray showed the presence of degenerative changes in the lower lumbar spine. In 1991, Dr. Lipp diagnosed lumbar disc syndrome. When Dr. Rasmussen

[19]For example, in *Merrill v. Todd Pacific Shipyards Corp.,* 25 BRBS 140 (1991), based on a treating physician's opinion that no new injury occurred when the claimant suffered severe back pain when doing yard work, the Benefits Review Board affirmed the administrative law judge's finding that the claimant's recurring back problems were natural and unavoidable consequences of his employment.

[20]According to the Benefits Review Board, if a claimant suffers a work-related injury to the right knee and as a consequence stresses and adversely affects the left knee, the condition of the left knee may be considered a natural and unavoidable consequence of the right knee injury, thereby becoming a work-related injury.

examined Mr. Gonzales at that time, she diagnosed lumbar strain associated with the use of a weed eater and observed the lumbar fusion and some narrowing at L4-5. In early February 2001, Dr. Lum reported that Mr. Gonzales occasionally experienced low back pain if he stressed his back.

Right after his left knee injury in June 2001, Mr. Gonzales developed a significant limp due to his damaged knee locking. On June 19, 2001, Dr. Rasmussen urged prompt corrective surgery due to developing back pain linked to the significant limp. Following surgery, multiple sessions of physical therapy, and quad muscle strengthening, Dr. Rasmussen reported Mr. Gonzales had recovered a normal gait in November 2001; it remained normal into January 2002. However, after the arrival of Mr. Cazinha in January 2002 and Mr. Gonzales' reassignment full-time to the smaller golf course equipment, he informed Dr. Rasmussen in April 2002 that he had difficulty getting on and off equipment at work. Upon examination, Dr. Rasmussen discovered that both the swollen left knee and altered gait had returned. Mr. Gonzales' notable limp continued into June 2002 through August 2002 and on to January 2003.

Less than a month after Dr. Rasmussen noted renewed left knee difficulties and a limp, Dr. Hager also observed on May 2, 2002 Mr. Gonzales' antalgic gait associated with his left knee injury. The physician diagnosed Mr. Gonzales with low back pain aggravation and cervical-thoracic sprain due to the left knee injury of June 1, 2001. Dr. Hager explained that when the nature of Mr. Gonzales' work changed in the spring of 2002, both his left knee pain and limp increased which in turn aggravated the pre-existing problems in his back and neck.

Even Dr. Ma acknowledged that the possibility that Mr. Gonzales' limp, which was directly related to his left knee injury, could have caused some stress to his low back, albeit a not a very severe injury. Dr. Ma clearly believed Mr. Gonzales had aggravated his pre-existing disc degenerative disc in April 2002.

C. Nature and Extent of Disability

In addition to continuing difficulties with his left knee, Mr. Gonzales has established the existence of low back and neck pain in the spring of 2002 as the natural consequence of his left knee injury-induced limp. In other words, he has suffered an injury in the form of an antalgic gait-induced aggravation of a pre-existing arthritic condition of his back and neck. To assess the appropriate amount of disability compensation for this aggravation injury, I must determine both the nature and extent of the associated disability.

Nature

As previously discussed, the nature of an impairment may be either temporary or permanent. Again, Dr. Ma and Dr. Hager have conflicting opinions. According to Dr. Ma, the aggravation to Mr. Gonzales' back that arose in April 2002 was only temporary and resolved within 12 weeks. In contrast, Dr. Hager believes Mr. Gonzales has not reached maximum medical improvement in regards to his back and neck condition; the nature of the back and neck injury remains temporary. Dr. Hager highlights that Mr. Gonzales continues to struggle with back and neck pain and that Dr. Smith has recommended epidural injections.

Previously, based on his more accurate interpretation of the spinal CT scans, I found Dr. Ma's opinion on the specific internal characteristics of the spinal problems to be more probative than Dr. Hager's assessment. However, due to a reasoning shortfall, I have less confidence in Dr. Ma's conclusion about the nature of the back pain symptoms and the extent to which they continue to bother Mr. Gonzales.

When Dr. Ma examined Mr. Gonzales in January 2003, about nine months after the spring 2002 date of aggravation, Mr. Gonzales described continued neck and low lumbar pain and his left knee pain also continued to cause him to limp. Upon evaluation, Dr. Ma also found limited neck range of motion and even diagnosed "minor residual pain" at the low back. Yet, in his May 2003 hearing testimony, Dr. Ma stated that whatever bothered Mr. Gonzales in April 2002 would have completely resolved within twelve weeks and by January 2003 he did not need any additional treatment. This conclusion is not well reasoned because, having not challenged the credibility of Mr. Gonzales' back pain complaints, Dr. Ma did not reconcile his hearing conclusion that Mr. Gonzales' left knee injury and limp-induced aggravated back problems had been completely resolved with his January 2003 examination findings of restricted neck movements, residual low back pain and continued left knee pain-induced limp. Further, while he disagreed with any additional physical therapy, Dr. Ma expressed no opinion on whether the recommended epidural injection therapy might provide relief to Mr. Gonzales for the back and neck problems he continued to present during Dr. Ma's January 2003 evaluation.

In contrast, although his assessment of the underlying skeletal nature of Mr. Gonzales' back problem was not as accurate as Dr. Ma's finding, Dr. Hager was in a better position through his treatment contacts with Mr. Gonzales to assess the duration, intensity and susceptibility of his back pain symptoms to further medical treatment and resolution. Based on this foundation, Dr. Hager has presented the better reasoned medical opinion on the symptomalogy of Mr. Gonzales' left knee injury-related low back and neck pain and the potential for future medical treatment. As a result, I find the nature of Mr. Gonzales' aggravated back and neck injury is temporary.

Extent

The question of the extent of a disability, total or partial, is an economic as well as a medical concept. *Rinaldi v. General Dynamics Corp*., 25 BRBS 128, 131 (1991). The Act defines disability as an incapacity, due to an injury, to earn wages which the employee was receiving at the time of injury in the same or other employment. *McBride v. Eastman Kodak Co*., 844 F.2d 797 (D.C. Cir. 1988). Total disability occurs if a claimant is not able to adequately return to his pre-injury, regular, full-time employment. *Del Vacchio v. Sun Shipbuilding & Dry Dock Co*., 16 BRBS 190, 194 (1984). A disability compensation award requires a causal connection between the claimant's physical injury and his inability to obtain work. The claimant must show an economic loss coupled with a physical and/or psychological impairment. *Sproull v. Stevedoring Servs. of America*, 25 BRBS 100, 110 (1991). Under this standard, a claimant may be found to have either suffered no loss, a partial loss, or a total loss of wage-earning capacity. Additionally, the employment-related injury need not be the sole cause, or primary factor, in a disability for compensation purposes. Rather, if an employment-related injury contributes to, combines with, or aggravates a pre-existing disease or underlying condition, the

entire resultant disability is compensable. *Strachen Shipping v. Nash*, 782 F.2d 531 (5th Cir. 1986).

To establish a *prima facie* case of total disability, whether temporary or permanent in nature, a claimant has the initial burden of proof to show that he cannot return to his regular or usual employment due to work-related injuries. *See Newport News Shipbuilding & Dry Dock Company v. Tann*, 841 F.2d 540, 542 (4th Cir. 1988). This evaluation of loss of wage-earning capacity focuses both on the work that an injured employee is still able to perform and the availability of that type of work which he can do. *McBride*, 844 F.2d at 798. At this initial stage, the claimant need not establish that he cannot return to any employment, only that he cannot return to his former employment. *Elliot v. C & P Tel. Co*., 16 BRBS 89 (1984). A claimant's credible testimony of considerable pain while performing work may be a sufficient basis for a disability compensation even though other evidence indicates the claimant has the capacity to do certain types of work. *Mijangos v. Avondale Shipping, Inc*., 948 F.2d 194 (8th Cir. 1999); *Anderson v. Todd Shipyards Corp*., 22 BRBS 20 (1989). Further, a physician's opinion that an employee's usual employment would aggravate his condition is sufficient to support a finding of total disability. *Care v. Washington Metro. Area Transit Auth.,* 21 BRBS 248 (1988).

Prima Facie Total Disability

On the ability of Mr. Gonzales to perform his regular employment, the medical experts again disagree. In November 2002, Dr. Rasmussen opined that the NA-5 machine operator requirements did not exceed her permanent work restrictions for Mr. Gonzales.[21] On July 25, 2002, Dr. Hager removed Mr. Gonzales from his work as a NA-5 machine operator due to his aggravated neck and back condition. In January 2003, Dr. Ma effectively sided with Dr. Hager, concluding that Mr. Gonzales should be permitted to retire since the combination of even light golf course duty and his pre-existing back problems would probably led to increased pain complaints.

In assessing relative probative value, I give Dr. Rasmussen's conclusion that Mr. Gonzales is capable of performing his usual duties less weight because her focus was principally on the limitations due to the left knee injury. Her limitations were specifically tied to the persistent left knee defects. Although prior to her determination the Employer provided Dr. Ma's assessment, Dr. Rasmussen did not explain the extent to which she considered Mr. Gonzales' additional work-related back and neck pain. Further, Dr. Rasmussen did not review Dr. Hager's findings. As a result, she was not fully aware of the full range of Mr. Gonzales' neck and back pain.

In contrast, on the issue of Mr. Gonzales' continued capacity to operate NA-5 vehicles, Dr. Hager's opinion is more consistent with the demonstrated pain symptoms and complications

[21]Following his left knee injury, Mr. Gonzales never returned to all his regular pre-injury machine operator duties. Specifically, prior to the June 2001 accident, he was expected to operate a dump truck. After the knee injury, Dr. Rasmussen's temporary and then permanent work restrictions precluded that job. Yet, by April 2002, Mr. Gonzales had essentially returned to working as an NA-5 machine operator, albeit with some duty changes, such that I consider his modified position to be his regular employment at the time of the April 2002 aggravated back injury.

Mr. Gonzales experienced in his back when he returned to solely driving NA-5 equipment in the spring of 2002. After Dr. Rasmussen performed left knee surgery and prescribed several courses of physical therapy, Mr. Gonzales was able to return to work in a limited, light duty capacity on August 29, 2001. Through a series of supervisor accommodations, including the assignment of Mr. Gonzales to larger golf course machines, which provided more leg room but were usually operated by higher grade NA-6 employees, Mr. Gonzales was able to work full-time at the golf course as a machine operator. However, upon the arrival of Mr. Cazinha in January 2002, and for various reasons, Mr. Gonzales was assigned solely to NA-5 vehicles. With that change in his equipment assignments in the spring of 2002, as documented by Dr. Rasmussen and Dr. Hager, Mr. Gonzales' left knee swelled again and he re-developed a significant limp. The renewed left knee problems and altered gait then aggravated his back and neck which lead to Mr. Gonzales' treatment with Dr. Hager. When the left knee complications persisted and the back pain did not resolve, Dr. Hager removed Mr. Gonzales from work on July 25, 2002 due to the unrelenting aggravation of his pre-existing back and neck degenerative disc condition caused by his operation of NA-5 machinery.

Thus, due to Dr. Rasmussen's narrow focus on the left knee injury, Dr. Hager's better understanding of Mr. Gonzales' back and neck pain, and Dr. Ma's supportive opinion on retirement, I conclude the more probative medical opinion has established a *prima facie* case of total disability. Due to the stress to the left knee associated with the operation of the NA-5 equipment, which in turn caused a limp and consequential painful aggravation of his pre-existing degenerative disc condition, Mr. Gonzales was unable to return to work in his usual employment as a NA-5 machine operator on July 25, 2002.

Suitable Alternative Employment

If a claimant is able to demonstrate he is unable to return to his former job, then in the second step of the disability adjudication process, the employer has the burden of production to show that suitable alternate employment is available. *Nguyen v. Ebbtide Fabricators*, 19 BRBS 142 (1986). The availability of suitable alternative employment involves defining the type of jobs the injured worker is reasonably capable of performing, considering his age, education, work experience and physical restrictions, and determining whether such jobs are reasonably available in the local community. *Newport News Shipbuilding and Dry Dock Co. v. Director, OWCP*, 592 F.2d 762, 765 (4th Cir. 1978) and *New Orleans (Gulfwide) Stevedores v. Turne*r, 661 F.2d 1031, 1038 (5th Cir. 1981). The showing of available suitable alternative employment may not be applied retroactively to the date of maximum medical improvement. An injured worker's total disability becomes partial on the earliest date that the employer shows suitable alternative employment. *Rinaldi v. General Dynamics Corp*., 25 BRBS 128, 131 (1991). A single job offer is sufficient to establish suitable alternative employment. *See Shiver v. United States Marine Base Exch.*, 23 BRBS (1990). An employer can meet its burden of production by offering the claimant a job in its facility, as long as the position does not represent sheltered employment.[22] *Spencer v. Baker Agricultural Co.*, 16 BRBS 205 (1984) and *Darden v. Newport*

[22]Sheltered employment involves the employment of a claimant due solely to the employer's beneficence rather than the necessity of having the work accomplished. *Walker v. Pacific Architects & Eng'rs.,* 1 BRBS 145, 146-48 (1974).

News Shipbuilding & Dry Dock Co., 18 BRBS 224 (1986). A claimant's retirement may represent a withdrawal from the work force. *Morin v. Bath Iron Works Corp.,* 28 BRBS 205 (1994). However, if the retirement is forced by a work-related condition, it is considered to be involuntary and a claimant is still entitled to a disability compensation award based on his loss of wage-earning capacity. *Id.* at 208.

On November 18, 2002, prior to receiving Mr. Gonzales' November 25, 2002 retirement with disability application, in response to his assertion, as confirmed by Dr. Hager, that his aggravated back condition precluded his return to his usual duty, Marine Corps MWR offered Mr. Gonzales a full time job as an identification card checker at the golf course for $6 an hour.

Although the actual job description of golf course checker is not in the record, Dr. Rasmussen reviewed the job's requirements in November 2002 and determined it met her June 2002 physical limitations for Mr. Gonzales. Thus, I conclude the job of golf course checker did not include any squatting, climbing, or kneeling. The checker would not have to lift anything heavier than 25 pounds or carry items weighing more than 15 pounds. The job required no more than one hour at a time of lifting and walking. And the standing requirement did not exceed two hours at a time.

In determining whether Mr. Gonzales was physically capable of this work, I return to the opinions of the same three physicians, Dr. Ma, Dr. Rasmussen, and Dr. Hager.

On the issue of suitable alternative employment, Dr. Ma simply expressed a belief that Mr. Gonzales was not totally disabled from any kind of work. That broad conclusion has little probative weight in determining whether the golf course checker job was suitable for Mr. Gonzales. In regards to specific jobs, Dr. Ma only addressed Mr. Gonzales' machine operator work and recommended that he be allowed to retire with a disability rather than continue his employment in that capacity. Dr. Ma expressed no opinion about the checker job.

Based on her endorsement, Dr. Rasmussen certainly considered the golf course checker job suitable for Mr. Gonzales. However, as previously discussed, her evaluations and treatments focused exclusively on Mr. Gonzales' left knee. Again, though Dr. Rasmussen was provided Dr. Ma's assessment, the record contains no information about the extent to which she considered Mr. Gonzales' aggravated back condition in approving the golf checker job for him. Additionally, Dr. Rasmussen did not review Dr. Hager's treatment notes, which is a significant documentary shortfall since I have found Dr. Hager's assessment of Mr. Gonzales' pain symptoms to be more probative than Dr. Ma's conclusions.

Since Dr. Hager provided the most probative assessment on the degree of Mr. Gonzales' back pain and his ability to continue to work as a machine operator, his opinion on whether Mr. Gonzales is capable of other types of work also has probative significance. Again, in addition to an extensive involvement with Mr. Gonzales' back problems, Dr. Hager also evaluated his left knee, was aware of the medical history associated with the knee, and observed the relationship between the injured knee, corresponding limp, and resulting aggravation of pre-existing degenerative disc disease. Based on his treatment of Mr. Gonzales, Dr. Hager concluded in a September 2002 treatment note that Mr. Gonzales was incapable of working any sedentary job

due to his severe back pain and intolerance of any requirement to stand or sit for long periods. While Dr. Hager indicated he was really not aware of the Employer's job offer, his September 2002 assessment of Mr. Gonzales' physical capacity is much more restrictive than Dr. Rasmussen's two hour standing limitation. Additionally, as a golf course checker, Mr. Gonzales could reasonably be expected to either stand or sit through the work day, contrary to Dr. Hager's credible limitations in those two areas.

Accordingly, due to the absence of Dr. Ma's evaluation of the checker position and the lack of an explanation by Dr. Rasmussen about the degree to which she factored in Mr. Gonzales' aggravated back condition, Dr. Hager's limitations on prolonged periods of sitting and standing cast sufficient doubt on the suitability of the Employer's golf course checker job offer for Mr. Gonzales. Since the Employer has failed to establish the suitability of the checker job and provided no other evidence of suitable alternative employment, I conclude that the extent of Mr. Gonzales' impairment due to his aggravated pre-existing degenerative disc disease in regards to his ability to earn wages is total.

Disability Compensation

At the time he submitted his retirement application, Mr. Gonzales was not able to return to his work and perform his usual duties as a NA-5 machine operator. In response to the retirement application, the Employer noted that he was not eligible for rehire due to his disability. As a result, his departure from the workforce due to retirement in November 2002 was not voluntary and does not preclude his entitlement to disability compensation associated with his loss of wage-earning capacity attributable to his aggravated back impairment.

Having established a *prima facie* case of total disability, and in the absence of suitable alternative employment, the extent of Mr. Gonzales' loss of wage-earning capacity became total on July 25, 2002 when Dr. Hager removed him from working as a machine operator due to his aggravated back condition. Based on the parties' stipulation, and in the absence of any indication that Mr. Gonzales' wages increased between June 2001 and July 2002, the applicable average weekly wage is $505.94. For the duration of the total loss wage earning capacity, Mr. Gonzales is entitled to temporary total disability compensation under Section 8 (b), 33 U.S.C. § 908 (b).

D. Medical Benefits

Under Section 7 (a) of the Act, 33 U.S.C. § 907 (a), if an employee suffers a compensable injury, then the employer is responsible for those reasonable and necessary medical expenses incurred as a result of a work-related injury to the extent the injury may require. *Perez v. Sea-Land Services, Inc.*, 8 BRBS 130 (1978). The employer's responsibility is continuing and exists even if a claim for disability compensation is time-barred by Section 12 and Section 13 of the Act, *Strachen Shipping co. v. Hollis,* 460 F.2d 1108 (5th Cir.) *cert. denied,* 409 U.S. 887 (1972), or fails to satisfy the Section 8 requirements for disability compensation, *Ingalls Shipbuilding v. Director, OWCP,* 991 F.2d 163, 166 (5th Cir. 1993). In other words, entitlement to medical services is never time-barred where a disability is related to a compensable injury. *Colburn v. General Dynamics Corp.*, 21 BRBS 219 (1988).

The employer must provide medical treatment for such period as the nature of the injury or the process of recovery may require. In order to hold the employer liable for medical expenses, the treatment must be both reasonable and necessary. *Parnell v. Capitol Hill Masonry*, 11 BRBS 532, 539 (1979). If the treatment is unnecessary for the injury, payment may be rejected. *Ballesteros v. Williamette W. Corp*., 20 BRBS 184, 187 (1988). On the other hand, if an administrative law judge determines a procedure is reasonable and necessary, then he or she may direct an employer to authorize a specific future surgical procedure. *Caudill v. Sea Tac Alaska Shipbuilding*, 25 BRBS 92, 98 (1991).

The claimant carries the burden to establish the necessity of medical treatment for, and that medical expenses are related to, a compensable injury. *See generally Schoen v. U.S. Chamber of Commerce,* 30 BRBS 112 (1996) and *Pardee v. Army & Air Force Exchange Service,* 13 BRBS 1130 (1981). A claimant may establish a *prima facie* case for compensable medical treatment if a qualified physician indicates the treatment is necessary for a work-related condition. *Turner v. Chesapeake & Potomac Tel. Co.,* 16 BRBS 255 (1984). At the same time, an employee may not receive an award of medical benefits absent evidence of medical expenses incurred in the past or treatment necessary in the future. *Ingalls,* 991 F.2d at 166.

Mr. Gonzales has suffered a compensable injury to his low back and neck through the aggravation of a pre-existing arthritic disc condition by his left knee injury-induced altered gait. Consequently, Marine Corps MWR is responsible for all necessary and reasonable medical treatment for that aggravated back condition.[23]

Further, as I have previously determined, in regards to Mr. Gonzales' back pain symptoms, Dr. Hager has provided a more probative assessment than Dr. Ma. As a result, I also find that Dr. Hager's concurrence with Dr. Smith's recommendation of epidural injections as a treatment of Mr. Gonzales' back pain prevails over Dr. Ma's conclusion that no further treatment is warranted. Accordingly, based on Dr. Hager's more probative recommendation, Mr. Gonzales has established that epidural injections are necessary medical treatments.

Issue No. 3 – Section 8 (f) Relief

Although I have not found that the aggravation of Mr. Gonzales' pre-existing arthritic disc condition resulted in a permanent impairment, I will nevertheless address the Employer's Section 8 (f) relief claim due to the untimely filing of the request.

Under Section 8 (f), and special circumstances, an employer may limit the extent of its liability for the payment of disability compensation claims involving permanent partial and total disability. If an employee had an existing permanent partial disability that was manifested to the employer upon hiring, and a subsequent work-related injury combines with the pre-existing permanent disability, the Special Fund will assume the Employer's responsibility for payment of the resulting disability compensation after a certain period of time depending on the type of injury. Significantly, Section 8 (f) (3) requires an employer to present its claim for Section 8 (f)

[23]Although I was not asked to address this issue, Mr. Gonzales seems to have exercised his choice of physician by selecting Dr. Hager and the corresponding consulting orthopedic surgeon, Dr. Smith.

relief to the District Director prior to consideration of the claim. Failure to comply with the filing requirement represents an absolute defense to the Special Fund's liability.

In April 2003, a representative for the District Director asserted an absolute defense against any claim by the Employer for Section 8 (f) relief because the issue had not been raised prior to the referral of the case to the Office of Administrative Law Judges. On May 5, 2003, Employer's counsel submitted an application for Section 8 (f) on the basis of information derived through discovery. The application did not address the asserted absolute defense. At the hearing, Ms. Kamaka indicated that by the time she became counsel for the Employer, the case had been forwarded to the Office of Administrative Law Judges (TR, pages 113 and 114). Mr. Gonzales testified that Marine MWR was aware of his previous back injury and impairment when he was hired in 1987. At least by October 2002, when Mr. Gonzales filed his second disability compensation claim, the Employer also became aware that he was claiming an additional injury and impairment to his back. Accordingly, having received sufficient notice of the potential for Section 8 (f) relief and failing to seek such relief from the District Director as required by Section 8 (f) (3), the claim by Marine Corps MWR for Section 8 (f) relief must be denied.

ATTORNEY FEE

Section 28 of the Act, 33. U.S.C. § 928, permits the recoupment of a claimant's attorney's fees and costs in the event of a "successful prosecution." Since I determined issues in favor of Mr. Gonzales, his attorney, Mr. Birnbaum, is entitled to recoup a portion of his fees and the costs associated with his professional work. Mr. Birnbaum has thirty days from receipt of his decision and order to submit an application for attorney fees and costs as specified in 20 C.F.R. § 702.132 (a). The Employer, and its counsel, Ms. Kamaka, have fifteen days from receipt of such fee application to file an objection to the request.

Because Mr. Gonzales was only partially successful, in their respective filings, both parties must address the analysis set out by the U.S. Supreme Court, in *Hensley v. Eckerhart,* 461 U.S. 424 (1983), made applicable to longshoreman claims in *George Hyman Const. Co. v. Brooks*, 963 F.2d 1532 (D.C. Cir. 1992).

ORDER

Based on my findings of fact, conclusions of law, and the entire record, I issue the following order. The specific dollar computations of the compensation award shall be administratively performed by the District Director.

1. The Employer, MARINE CORPS MWR, **SHALL PAY** the Claimant, MR. FRANK GONZALES, JR., compensation for **PERMANENT PARTIAL DISABILITY** due to a permanent 20% loss of use of his left leg caused by a left knee injury on June 1, 2001, based on an average weekly wage of $505.94, starting June 6, 2002, in accordance with Section 8(c) (2) and Section 8(c) (19) of the Act, 33 U.S.C. §§ 908 (c) (2) and 908 (c) (19).

2. The Employer, MARINE CORPS MWR, **SHALL PAY** the Claimant, MR. FRANK GONZALES, JR., **ADDITIONAL COMPENSATION** for overdue permanent partial disability payments established in paragraph 1 of this order, for the period from August 8, 2002 through October 23, 2002, such compensation to be computed in accordance with Section 14 (e) of the Act, 33 U.S.C. § 914 (e).

3. The request by the Claimant, MR. FRANK GONZALES, JR., to change physicians in regards to the treatment of his left knee due to an injury on June 1, 2001 is **DENIED**.

4. The Employer, MARINE CORPS MWR, **SHALL PAY** the Claimant, MR. FRANK GONZALES, JR., compensation for **TEMPORARY, TOTAL DISABILITY**, from July 25, 2002, and continuing, based on an average weekly wage of $505.94, for aggravation of his pre-existing back and neck degenerative disc condition caused by an altered gait due to a left knee injury on June 1, 2001, in accordance with Section 8 (b) of the Act, 33 U.S.C. § 908 (b).

5. The Employer, MARINE CORPS MWR, **SHALL FURNISH** to the Claimant, MR. FRANK GONZALES, JR., such reasonable, appropriate, and necessary **MEDICAL CARE AND TREATMENT** as the aggravation of his pre-existing back and neck degenerative disc condition caused by an altered gait due to a left knee injury of June 1, 2001 may require, including prescribed epidural injections, in accordance with Section 7 (a) of the Act, 33 U.S.C. § 907 (a).

6. The claim of the Employer, MARINE CORPS MWR, for relief under Section 8 (f) is **DENIED**.

7. The Employer, MARINE CORPS MWR, **SHALL RECEIVE CREDIT** for all amounts of disability compensation previously paid to the Claimant, MR. FRANK GONZALES, JR., as a result of his left knee injury on June 1, 2001.

SO ORDERED:

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: September 30, 2004
Washington, DC

Attachment No. 1

American Board of Medical Specialties

Certification:

Linda J. Rasmussen, MD

Certified by the American Board of Orthopedic Surgery in:

Orthopedic Surgery

American Board of Medical Specialties
1007 Church Street, Suite 404
Evanston, IL 60201-5913
Phone Verification: (866) ASK-ABMS
Phone: (847) 491-9091/FAX: (847) 328-3596

HTTP://www.abms.org